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**FIRST STEPS IN
ORGANIZING A HOSPITAL**



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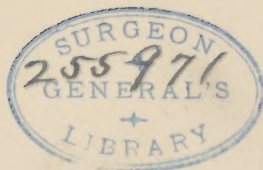
FIRST STEPS IN ORGANIZING A HOSPITAL

AN EXPOSITION OF IDEALS AND PRINCIPLES INCIDENT
TO THE INCEPTION AND ORGANIZATION OF A HOSPITAL

BY

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New York
THE MACMILLAN COMPANY
1924

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Set up and electrotyped.
Published May, 1924.

WX
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Film 8746 24mm /

Printed in the United States of America by
J. J. LITTLE AND IVES COMPANY, NEW YORK

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To
DR. S. S. GOLDWATER

PREFACE

IN the preparation of this book the writer has had in mind not so much the organization of the larger hospitals in our metropolitan districts as of the typical community hospital, quite irrespective of where it may be located. The book is essentially a handbook and in no sense an exhaustive treatise on the subject. An effort has, therefore, been made to limit the discussion to the practical phases of the subject, arranged in the order in which they will probably come up for consideration by any group of citizens interested in the organization of a community hospital. It is, moreover, one of a series of projected handbooks on various phases of hospital organization, construction and management, and this fact should be kept in mind in perusing its pages.

Believing that a general conception of the hospital field will be helpful to any individual or citizens' committee contemplating the organization of a new hospital, the writer has devoted the introduction to a brief presentation of the field as it exists today. Statistics which appear in this introduction are taken very largely from the recently issued fourth edition of "The Modern Hospital Year Book."

It is difficult to indicate which of the steps dealt with in this volume are most essential or to place them in the order of their relative importance. All are essential, but the writer will feel that he has fallen short of his purpose in preparing this book if he has failed to impress upon its readers the vital importance of making a survey of the community preliminary to constructing a hospital. Only by taking this step shall we have hospitals that are properly located, that do not duplicate or overlap the work of other institutions, that have a classification of beds suited to the needs of the community, that can be augmented without being distorted and that can render the community maximum service at a minimum expense.

The writer wishes to express his appreciation to a number of individuals for assistance in the preparation of this little volume: To Dr. Malcolm T. MacEachern, president of the American Hospital Association, for material included in Chapters III and V; to Mr. Michael M. Davis, Jr., executive secretary of the Committee on Dispensary Development, United Hospital Fund of New York, for helpful suggestions leading to improvements in both the substance and arrangement of Chapter I; to Mr. Maurice Biscoe, architect, Boston, for helpful data on the factors that should be considered in the selection of a hospital site; to Mr. Perry W. Swern, architect, Chicago, and Mr. Carl A. Erikson, architect, Chicago, for helpful suggestions on the

employment of the hospital architect, and to Dr. S. S. Goldwater, director of Mount Sinai Hospital, New York, and Miss Donelda R. Hamlin, director of the Hospital Library and Service Bureau, Chicago, whose critical study of the entire manuscript led to the inclusion of pertinent material that would otherwise have been omitted.

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ORGANIZING A HOSPITAL**

FIRST STEPS IN ORGANIZING A HOSPITAL

INTRODUCTION

THE HOSPITAL FIELD OF TODAY

To the individual or citizens' committee faced with the interesting task of organizing an entirely new hospital, a general conception of the hospital field in which the new institution is to take its place cannot but be an inspiration. It seems to the writer of this book, therefore, that the opening chapter, while not bearing directly on the specific subject of the book, might very appropriately be devoted to an analysis of the hospital field as it exists today.

GROWTH OF HOSPITAL SERVICE

The growth in the number of hospitals during the last half century is little less than marvelous. That this is not an over-statement is apparent from the fact that, whereas in 1873 there were only 149 hospitals in the United States, an annual survey which has just been completed by *The Modern Hospital* shows that

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at the beginning of 1923 there were in the United States and its possessions 7,095 hospitals and sanatoriums. These institutions have a total patient bed capacity of 792,069. This is exclusive of the 232,099 beds used for hospital purposes by allied institutions, such as homes for the aged, children, the blind, and the deaf. There has, therefore, been an increase of 4,661 per cent in the number of hospitals and sanatoriums during the past fifty years, and of 2,161 per cent in the number of beds for patients.

DECREASE IN AVERAGE BED CAPACITY IN LAST FIFTY YEARS

In this connection it is interesting to note that during this half century there has been a marked decrease in the average bed capacity of the hospitals. The bed capacity of the 149 hospitals in existence in the country in 1873 averaged 238. With few exceptions, these hospitals were located in the larger centers of population. But the average bed capacity of the hospitals and sanatoriums in existence today is only 111. This is because hundreds of smaller cities and many village and rural communities now have hospital facilities, where a large bed capacity to an individual hospital is not required.

GROWTH OF HOSPITALS DURING PAST FIFTY YEARS

The inspiring growth of the hospital field during the past fifty years is shown in Table I:

TABLE I

HOSPITALS IN THE UNITED STATES AND ITS POSSESSIONS

	1873	1923	PER CENT OF INCREASE
Number of hospitals	149	7,095	4,661
Number of hospital beds.	35,453	792,069	2,162
Population	38,558,371	105,710,620	174

NUMBER OF HOSPITALS BY STATES

The reader will be interested in knowing the number of hospitals in his state at the beginning of 1923 and their total bed capacity. Consequently there follows a table (Table II), showing the distribution of the hospitals of the United States and its possessions, and their bed capacity according to states:

TABLE II

DISTRIBUTION OF HOSPITALS AND ALLIED INSTITUTIONS BY STATES

STATE	NUMBER OF HOS- PITALS AND ALLIED INSTITUTIONS	TOTAL NUMBER OF BEDS
Alabama	108	7,622
Arizona	67	4,087
Arkansas	67	5,103
California	487	49,330
Colorado	149	13,186
Connecticut	116	15,712
Delaware	21	1,792
District of Columbia	68	12,532
Florida	92	7,065
Georgia	130	12,743
Idaho	57	3,257
Illinois	443	62,562
Indiana	231	24,144
Iowa	249	19,601
Kansas	167	13,765
Kentucky	164	17,130
Louisiana	80	11,826
Maine	91	8,860
Maryland	151	20,002

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DISTRIBUTION OF HOSPITALS AND ALLIED INSTITUTIONS BY STATES— *Continued*

	NUMBER OF HOS- PITALS AND ALLIED INSTITUTIONS	TOTAL NUMBER OF BEDS
Massachusetts	447	48,544
Michigan	273	30,551
Minnesota	261	25,216
Mississippi	66	7,071
Missouri	236	29,030
Montana	105	7,454
Nebraska	144	11,949
Nevada	27	1,288
New Hampshire	85	5,946
New Jersey	231	30,322
New Mexico	59	4,696
New York	896	159,723
North Carolina	149	13,192
North Dakota	66	5,315
Ohio	454	60,639
Oklahoma	124	9,902
Oregon	131	9,808
Pennsylvania	608	90,039
Rhode Island	57	7,549
South Carolina	75	6,497
South Dakota	76	6,386
Tennessee	149	16,014
Texas	288	27,125
Utah	50	3,672
Vermont	47	3,716
Virginia	164	19,819
Washington	192	15,328
West Virginia	84	7,398
Wisconsin	278	26,132
Wyoming	44	2,888
United States Possessions	190	20,640
	8,994	1,024,168

RATIO OF HOSPITAL BEDS TO POPULATION BY STATES

That there is a wide variation in the development of hospital service in the various states will be still more apparent from an examination of Table III which gives the ratio of active hospital beds to population. By "active" is meant beds which are available for acute

medical and surgical cases. The term does not include the beds of hospitals and sanatoriums for the care and treatment of the tuberculous, the mentally and nervously ill, the crippled, the chronically ill, the convalescent, the alcoholic, the drug addict and others having special diseases.

TABLE III
RATIO OF HOSPITAL BEDS TO POPULATION

STATE	POPULATION	NUMBER OF HOS- PITALS	NUMBER OF BEDS	RATIO OF ACTIVE HOSPITAL BEDS TO POPULATION, JAN. 1, 1923
Alabama	2,348,174	86	6,108	1 to 384
Arizona	334,162	64	3,790	1 to 88
Arkansas	1,752,204	56	3,880	1 to 452
California	3,426,861	414	38,493	1 to 90
Colorado	939,629	113	10,239	1 to 92
Connecticut	1,380,631	77	11,255	1 to 120
Delaware	223,003	14	1,263	1 to 177
District of Columbia	437,571	27	8,322	1 to 53
Florida	968,470	81	5,949	1 to 163
Georgia	2,895,832	101	10,753	1 to 269
Idaho	431,866	50	2,815	1 to 154
Illinois	6,485,280	313	44,858	1 to 144
Indiana	2,930,390	144	16,414	1 to 117
Iowa	2,404,021	194	14,291	1 to 167
Kansas	1,769,257	130	9,714	1 to 182
Kentucky	2,416,630	99	10,692	1 to 226
Louisiana	1,798,509	55	8,622	1 to 208
Maine	768,014	67	5,099	1 to 150
Maryland	1,449,661	68	11,802	1 to 122
Massachusetts	3,852,356	282	34,733	1 to 110
Michigan	3,668,412	206	22,737	1 to 161
Minnesota	2,387,125	215	21,502	1 to 111
Mississippi	1,790,618	53	5,830	1 to 308
Missouri	3,404,055	152	20,159	1 to 168
Montana	548,889	93	6,099	1 to 89
Nebraska	1,296,372	106	8,202	1 to 158
Nevada	77,457	24	975	1 to 79
New Hampshire	443,083	54	3,409	1 to 129
New Jersey	3,155,900	139	20,544	1 to 153
New Mexico	360,350	54	4,335	1 to 82
New York	10,385,227	530	98,038	1 to 106

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RATIO OF HOSPITAL BEDS TO POPULATION—*Continued*

STATE	POPULATION	NUMBER OF HOS- PITALS	NUMBER OF BEDS	RATIO OF ACTIVE HOSPITAL BEDS TO POPULATION, JAN. 1, 1923
North Carolina	2,559,127	118	9,689	1 to 264
North Dakota	646,872	60	4,985	1 to 129
Ohio	5,759,394	279	39,280	1 to 146
Oklahoma	2,028,283	108	7,846	1 to 258
Oregon	783,389	101	9,001	1 to 87
Pennsylvania	8,720,017	377	59,317	1 to 147
Rhode Island	604,397	30	4,424	1 to 136
South Carolina	1,683,724	65	5,377	1 to 313
South Dakota	636,547	65	4,949	1 to 128
Tennessee	2,337,855	102	9,863	1 to 237
Texas	4,663,228	242	21,160	1 to 220
Utah	449,396	40	2,587	1 to 174
Vermont	352,428	34	2,271	1 to 155
Virginia	2,309,187	106	11,219	1 to 205
Washington	1,356,621	160	12,020	1 to 112
West Virginia	1,463,701	74	6,416	1 to 228
Wisconsin	2,672,067	188	13,138	1 to 192
Wyoming	194,402	38	2,178	1 to 89
U. S. Possessions	12,148,875	181	19,451	1 to 624
				1 to 177

The ratios given in Table III, it should be emphasized, apply broadly to each state as a whole. The ratio of hospital beds to population for each community in the state may vary widely from the ratio which applies to the state as a whole and from the ratio which authorities, in the absence of any measurably scientific determination of the question, roughly regard as the minimum ratio that should prevail if a community is to provide the hospital service which modern needs demand.

To determine roughly, therefore, whether it does or does not need additional hospital facilities, each com-

munity must ascertain its own existing ratio of hospital beds to population, always bearing in mind that this is not solely a matter of population and morbidity.

Furthermore, in making a comparative study of the ratios in Table III, it should be borne in mind that, while these figures indicate in a very general way the sections of the country where hospital facilities are still most urgently needed, states which have large centers of population (with the consequent greater hazards of their industrial and commercial activities, as well as congested housing conditions) require a higher percentage of hospital beds to population. This higher percentage is also required by virtue of the fact that many patients residing at a distance seek the special service of metropolitan hospitals.

FACTOR MAKING FOR HIGHER RATIO IN CERTAIN STATES

In interpreting the figures in Table III it should also be remembered that states such as California, Colorado, Arizona and Nevada, the climatic conditions of which are thought to be more conducive than others to rapid recovery from certain types of disease, inevitably have a higher ratio of beds to population, since many of their institutions are devoted to the care of patients from other sections of the country, who would not be counted in the census of the state in which the hospital service is given.

For a further discussion of the subject of the ratio

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of hospital beds to population the reader is referred to Chapter I, page 21.

CLASSIFICATION OF HOSPITALS ACCORDING TO SIZE

Hospitals vary greatly in size, ranging in capacity from a minimum in a few instances of less than ten beds to a maximum of one thousand beds and more. It will be observed, however, from Table IV that the great majority of hospitals, some 82 per cent, have a capacity of less than one hundred beds; 60 per cent

TABLE IV
CLASSIFICATION OF HOSPITALS ACCORDING TO SIZE

	TOTALS	PER CENT
40 beds and under	4,257	60
41 beds to 99 beds	1,561	22
100 beds and over	1,277	18
	7,095	100

have a capacity of less than forty-one beds. In this connection it should be observed that, while 111 beds is the average size of all the hospitals in this country, this is not a true cross-section of the hospital field, for, as just indicated, 82 per cent of the hospitals have a capacity of less than one hundred beds. It is the large bed capacity of the relatively large number of the remaining 18 per cent that gives us this high average bed capacity.

DISTRIBUTION OF HOSPITALS ACCORDING TO SIZE OF COMMUNITY

A study of the distribution of hospitals in cities and rural communities reveals several significant things.

For example, 3,366 hospitals giving an active service, or nearly one half of the hospitals in the United States (not including its possessions), are located in cities with a population of 10,000 or less, or in rural communities; while only 1,546, or less than one fourth, are located in our larger cities; that is, in cities with a population of 100,000 or over. The remaining one fourth are in cities having a population of less than 100,000 and more than 10,000.

TABLE V

DISTRIBUTION OF HOSPITALS ACCORDING TO SIZE OF CITY—NOT INCLUDING UNITED STATES POSSESSIONS

	NUMBER OF CITIES	NUMBER OF HOSPITALS	PER CENT
100,000 population and over	68	1,546	22
50,000 to 100,000	76	446	6
25,000 to 50,000	143	532	8
10,000 to 25,000	459	1,001	15
10,000 and under	14,946	3,366	49

It is interesting to note that there are about as many hospitals in cities having a population of 25,000 or less, and in rural communities, as there are hospitals of forty beds and under. While this does not mean that all the hospitals of forty beds and under are located in the small cities and rural districts, it is fair to say that the majority of them are. For further details as to the distribution of hospitals the reader is referred to Table V.

PUBLICLY OWNED HOSPITALS

In classifying hospitals in relation to the community they naturally fall into two main groups: (a) public

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service hospitals; (b) proprietary hospitals. The first group may be further sub-divided into hospitals that are owned and conducted by the federal, state, county or city government, and those owned and conducted, not for profit, by religious bodies, fraternal organizations or private corporations. The number of publicly owned and managed hospitals and their distribution among the different states is shown in Table VI.

TABLE VI

NUMBER AND DISTRIBUTION OF PUBLICLY OWNED HOSPITALS

STATE	FEDERAL	STATE	COUNTY	CITY
Alabama	3	3	3	6
Alaska	1			3
Arizona	6	4	7	2
Arkansas	2	1	1	1
California	9	15	55	20
Canal Zone	1			1
Colorado	4	3	12	11
Connecticut	1	8	4	20
Delaware	1	1	1	1
District of Columbia	6	1		1
Florida	5	3	3	8
Georgia	8	7	3	15
Guam	1			
Hawaii	2	1		7
Idaho	1	5	3	5
Illinois	7	13	15	25
Indiana	2	12	18	14
Iowa	2	12	8	20
Kansas	4	8	10	10
Kentucky	7	8	6	12
Louisiana	7	7		6
Maine	4	8	4	7
Maryland	3	11	3	9
Massachusetts	8	26	9	38
Michigan	2	14	7	26
Minnesota	3	12	5	19
Mississippi	1	8	1	5
Missouri	6	8	4	7
Montana	1	4	13	5
Nebraska	2	6	4	11
Nevada		3	6	

NUMBER AND DISTRIBUTION OF PUBLICLY OWNED HOSPITALS—
Continued

STATE	FEDERAL	STATE	COUNTY	CITY
New Hampshire	1	4	4	3
New Jersey	1	8	22	20
New Mexico	5	4	1	2
New York	9	24	33	44
North Carolina	5	5	2	6
North Dakota	1	3	3	3
Ohio	5	11	18	25
Oklahoma	2	15	5	12
Oregon	3	5	5	6
Pennsylvania	8	30	23	40
Philippine Islands	13	5	2	6
Rhode Island	2	7	1	4
South Carolina	5	6	2	4
South Dakota	1	4	2	5
Tennessee	4	6	4	10
Texas	5	12	8	22
Utah	1	2	2	4
Vermont	1	4	2	3
Virginia	5	10	4	13
Virgin Islands	1			2
Washington	9	5	8	20
West Virginia		9	8	11
Wisconsin	4	10	45	32
Wyoming	3	4	3	6
	204	405	412	618

It will be evident from Table VI that there are 1,639 public service hospitals under government control, be it federal, state, county or municipal. The balance of the total number of hospitals are owned and administered either by religious bodies, fraternal organizations or private corporations, with no thought of making a profit, or by individuals and corporations who are conducting their hospitals for profit.

Hospitals listed under federal control include the hospitals for the care and treatment of war veterans, and the hospitals connected with the various National

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Homes for Disabled Volunteer Soldiers. The hospitals listed under state control include hospitals for epileptics and the mentally ill. They do not include so-called county asylums or allied institutions, such as homes for the deaf, dumb and blind.

TABLE VII
HOSPITALS BY CLASSIFICATION OF SERVICE

	NUMBER
General	4,940
Surgical	206
Tuberculosis	520
Contagious	169
Industrial	251
Convalescent	86
Ear, eye, nose and throat	71
Cancer	20
Mental and nervous	580
Maternity	178
Children's	74
	7,095

TYPE OF SERVICE

As is evident from Table VII, general hospitals (*i. e.*, hospitals rendering a varied service such as medical, surgical, obstetrical and pediatric) predominate, being 69 per cent of a total of 7095 rendering an active service.

It is interesting, however, to note the large number of hospitals rendering a specialized type of service, among which hospitals for the care and treatment of mental and nervous cases take the lead, with hospitals and sanatoriums for the tuberculous closely following.

DISTRIBUTION OF COUNTY HOSPITALS ¹

There are in the United States only 465 county hospitals maintained by 361 counties, although there are 3,066 counties in the United States. These 465 hospitals have a total bed capacity of 46,571 beds, with an average occupancy of 32,785 patients. The State of California leads with 56 hospitals of this type, New York is a close second with 50 county hospitals, Indiana has 27, Illinois 26, New Jersey 24, Ohio 23, Pennsylvania 21 and Michigan 20. Georgia, Louisiana, Mississippi and Rhode Island have no hospitals maintained by county funds. The absence of a county hospital does not, of course, imply that the county is wholly without hospital service; in fact, 49.6 per cent of the counties of the United States have at least one hospital, even though it may be a proprietary institution.

HOSPITAL LABORATORIES

In recent years there has been a very decided growth in the number of laboratories established in the hospitals of the United States, and a marked improvement in the quality and scope of their service. Three thousand and thirty-five hospitals now report that they maintain a laboratory service of some sort or other.

¹ The figures contained in this and succeeding paragraphs are taken from the January 12, 1924, hospital number of the *Journal of the American Medical Association*.

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Three hundred and one of these clinical laboratories are in hospitals having a capacity of more than 300 beds; 658 are maintained by hospitals having from 100 to 300 beds; 1,366 are in hospitals having a capacity of from between 26 to 100 beds, and 710 are maintained by hospitals of 25 beds or less.

ROENTGEN RAY DEPARTMENTS

Fewer hospitals by approximately 200 have Roentgen ray departments than have laboratories. A total of 2,841 hospitals maintain Roentgen ray departments. Two hundred and forty-six of these departments are located in hospitals having over 300 beds; 642 in hospitals having from 100 to 300 beds; 1,281 in hospitals having from 26 to 100 beds and 672 in hospitals having 25 beds or less. Many of the smaller hospitals are, of course, in a position to have their Roentgen ray work done outside the institution.

The seven types of hospitals leading in the number of their Roentgen ray department are as follows: general hospitals 2,149; nervous and mental hospitals 129; tuberculosis hospitals 181; maternity hospitals 29; children's hospitals 23; eye, ear, nose and throat hospitals 19; orthopedic hospitals 16.

HOSPITALS MAINTAINING SCHOOLS OF NURSING

There are 1,964 schools of nursing in the United States. One hundred and seventy-seven, or 9 per cent,

are in hospitals of over 300 beds; 495, or 25.2 per cent, are in hospitals of from 100 to 300 beds; 1,031, or 52.5 per cent, are in hospitals of from 26 to 100 beds; while 261, or 13.3 per cent, are in hospitals of 25 beds or less. Many of our largest hospitals are institutions for the nervous and mentally ill and for the tuberculous and cannot, therefore, provide a general training for nurses. This situation in part accounts for the low percentage of training schools in our largest institutions.

The hospitals in the different types maintaining nursing schools are as follows: General 1,639; nervous and mental 108; tuberculosis 31, maternity 44; industrial 24; children's 19; isolation 2; convalescent and rest 4; eye, ear, nose and throat 8; orthopedic 4; skin and cancer 2; all others 79.

There are at present 1,586 schools of nursing accredited by state boards. With 1,964 schools as the total number in the United States, there are at least 378 that are not accredited. While these unaccredited schools help the hospitals with which they are connected in keeping their supply of nurses, they are, nevertheless, as *The Journal of the American Medical Association* properly points out, somewhat of a menace to the inexperienced young people who take their courses for which credit is not given by any state board.

There is no absolutely accurate information as to the total number of pupil nurses in the 1,964 training schools in the United States, but according to the re-

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port of the committee for the study of nursing education there were, in 1921, 55,000 pupil nurses in the hospitals, and approximately 15,000 were being graduated each year.

MINIMUM STANDARDS OF MEDICAL SERVICE

Owing to the pressing demand for greater hospital service during the past three or four decades, and the consequent rapid increase in the construction and organization of hospitals, they have, in many instances, not given their standards of medical and surgical service the consideration they should. But with the inauguration of the so-called standardization movement of the American College of Surgeons in 1918, there has been a growing development in the efficiency of many hospitals, especially along the lines of the minimum standard of the College, with the result that its list of approved hospitals published at the meeting of the college in October, 1923, showed a total of 1,176 hospitals. Seven hundred and forty-nine of these are hospitals of 100 beds and over and 427 are hospitals of 50 to 99 beds. These hospitals have a total bed capacity of 191,042 beds.

The minimum standards of the College require (1) that the doctors practicing in the hospital shall be organized as a staff; (this organization may be carried out either in an "open" or a "closed" hospital); (2) that the medical staff of the hospital shall be com-

petent and ethical; (3) that the medical staff shall draw up rules and regulations for the guidance of the professional work of the hospital; (4) that the medical staff shall hold conferences periodically and at least once every month for the purpose of making an analysis and reviewing the work carried on in the institution; (5) that there shall be a complete medical case record of every patient passing through the institution; (6) that the hospital shall maintain an efficient laboratory and x-ray service.

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CHAPTER I

SURVEYING THE COMMUNITY PRELIMINARY TO HOSPITAL CONSTRUCTION

ANYONE who is at all well informed as to the development of the hospital field is painfully conscious of the higgledy-piggledy, inefficient way in which the hospital needs of various communities have been met.

From the standpoint of the community, hospitals have, with rare exceptions, to use the apt characterization of the Cleveland Hospital and Health Survey, been "planted each by itself, instead of being planned as part of a community scheme for an organized medical service." Many communities in this country are altogether lacking in hospital facilities; other communities have some, but by no means adequate, hospital facilities; not a few are lacking in facilities for the treatment of special diseases and groups of cases; not a few hospitals are located in the wrong place. They encroach upon the legitimate territory of other institutions; they are difficult of access to the people they were built to serve; they are built at points that will not admit of inevitable expansions; they are not located according to any general plan, nor with refer-

ence to the needs of any particular community. Some, though their number is not large, have too many beds; others have too many beds for particular types of cases. Many hospitals, due to a lack of long-range plans, are badly balanced. Owing to a lack of flexibility in the plans and construction, the service building, the power plant or the nurses' home, as originally conceived and built, is too small to meet the institution's growing needs.

Deplorable, and sometimes serious, conditions such as these have resulted in most instances because the problem of meeting the hospital needs of any given community has not been approached in an orderly and scientific way. On the contrary, whenever an individual or a group of individuals representing private or public interests faces the problem of building a hospital, the initial approach is such as to lead almost inevitably to the construction of an institution which embodies many avoidable mistakes and which, in one way or another, does not and cannot be developed to meet adequately and efficiently the reasonable needs of the community it is built to serve. All too often the question as to whether or not a hospital should be built, and the determination of its location, size, type and facilities is decided by the will or wish of some wealthy individual, by the predilection of some prominent physician or surgeon, by the apparent demand for increased hospital facilities, or by the pride

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of a community and its unwillingness to let a rival community seem to surpass it in providing for the institutional care of the sick.

THE ORDERLY AND SCIENTIFIC SURVEY

There is another and a better way for a community, whether it be as large as New York City or Chicago or as small as Kahoka, Ark., to approach the problem of its hospital needs. It is the way of the orderly and scientific survey. The purpose of such a survey is to determine pertinent facts through a thorough-going study of the community, free from any haste, bias or preconceived notions, and to present them with the accuracy and impartiality that mark the method of the laboratory in the field of physics, biology or chemistry. There must be a definite stock-taking of the facts that determine size, location, facilities and service, with a view to providing whatever information may be necessary for the basis of a constructive, long-range plan.

Before entering upon a discussion of the way in which a preliminary survey of the community should be conducted, it would be well to outline some of the facts which are at present known regarding the amount of hospital service carried by various communities. This may well be followed by a brief discussion of what proportion of those who are sick go to hospitals and the extent to which existing hospital beds are put to use.

RATIO OF BEDS TO POPULATION IN VARIOUS COMMUNITIES

In 1912 a study was made by the committee on hospitals of the New York State Charities Aid Association of some thirty or forty of the smaller hospitals located in New York State. It was found that the ratio of beds to population in these communities was one bed to 300 of the population; most of these hospitals, however, were asking for more beds. Tables showing the ratios in detail may be found in appendix two of a report issued by the association on "A Medical Hospital in the Tonawandas." A survey of the hospitals in so-called greater Cleveland, made in 1920, showed that the ratio of beds to population was then 2.8 beds to 1,000 of the population. In determining this ratio only hospitals for general and special cases of an acute or chronic nature and for convalescents were considered. Hospital beds for the insane and feeble-minded and for the aged, as well as those in orphanages and under the control of the United States government were excluded. A survey of the hospitals in New York City made in recent years shows a ratio of five hospital beds to every 1,000 of the population. The metropolitan district of Boston with a total population of 1,500,000, according to the 1920 census, has 140 general and special hospitals with a total of 7,247 beds. This gives a ratio of 4.83 beds to 1,000 of the population. New York and Boston have approximately the same ratio.

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FACTORS INFLUENCING RATIO OF BEDS TO POPULATION

It is evident from these varied ratios that it is impossible to advance a claim of any normal ratio of hospital beds to the population. Indeed, our present inadequate knowledge of the social relations of hospitals alone would make such a claim worthless. The ratio will probably run higher in urban communities than in suburban or rural communities, as, in the former, hospitals are more readily accessible to a relatively larger number of people. The type of city, moreover, will influence the ratio. It will be higher in industrial cities where the workers are subject to all the hazards of industry and where homes are not infrequently less suited to the care of the sick than in residential cities.

The housing conditions of a community have a direct bearing upon this ratio. Cities in which apartment houses or rooming houses predominate will make greater demand on their hospital facilities than communities in which the homes of the well-to-do prevail. The wealthy can often, particularly in minor illnesses, be cared for in their homes, while the apartment-house or rooming-house dwellers are almost compelled to seek admission to hospitals if they are to receive the care and privacy their illness demands. Then again, people of wealth are apt to complete their convalescence at home rather than in the hospital. This results in a

more rapid turnover and tends to reduce the number of beds needed.

Cities subject to a floating population, such as sea-ports which often serve as the terminals of national and international railway and steamship lines, and cities located near construction camps and mills, will require a higher ratio of beds to population than cities with a more or less stable population. The presence of out-patient departments and dispensaries will increase the number of in-patients, thereby indicating a higher ratio of beds to population.

Cities that draw from the surrounding country or from considerable distances, due to a lack of hospital facilities in the country or the outstanding ability of some of the physicians and surgeons connected with its institutions, will require a higher ratio of beds. Clearly it is evident that this question is not solely one of population and morbidity; it is complicated by social, industrial, financial, and even religious factors, as well as by questions of transportation and public and domestic hygiene. But meager as is the data for estimating the normal ratio, it is undoubtedly fair to say that the burden of proof rests on the community with unsatisfactory health conditions to demonstrate that its hospital provisions are adequate, if the proportion of beds is as low as one to 300 inhabitants.

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NUMBER OF SICK WHO GO TO HOSPITALS

Additional light may be thrown on this problem by a study of the percentage of sick who actually go to the hospitals of a given community, taken in relation to the number of sick who should go because of the complex nature of their diseases or home conditions inimical to adequate care, but who for various reasons—social, financial, educational, religious and geographical—do not. Some of these percentages as applied to particular communities have already been published. Under the direction of Mr. Henry C. Wright, the Committee on Inquiry into the Departments of Health, Charities and Bellevue and Allied Hospitals, appointed by the Board of Estimate and Apportionment of the City of New York, made a house-to-house inquiry in an East and a West Side district in New York City in the spring of 1913. This study showed that 10 per cent of the people that had been sick in these districts received hospital care, while the remaining 90 per cent were cared for in their homes. The community sickness surveys made by the Metropolitan Life Insurance Company among the families of its industrial policyholders in three widely separated cities showed that in Kansas City 8.7 per cent of the sick persons covered by the study received hospital care; in Pittsburgh, 14 per cent and in Boston, 24.2 per cent. Basing its estimate upon conclusions reached through the study of sick-

ness made by the Metropolitan Life Insurance Company and by other agencies, which show that from 2 to 3 per cent of the population of cities like Cleveland are usually sick at any one time, the Cleveland Health and Hospital Survey states that 10 per cent of the sick of Cleveland, or from 2,000 to 3,000 out of a probable 20,000 or 30,000 sick persons, are cared for in hospitals. This does not take into consideration minor ailments and diseases not causing incapacity.

The study of sickness in Dutchess County made in 1913 by the New York State Charities Aid Association likewise shows that 10 per cent of the 1,600 patients studied received hospital care.

These and other studies of this subject indicate that the proportion of sick people who go to hospitals varies from 5 per cent to 20 per cent. Whether the proportion in any given community is nearer the minimum or maximum percentage depends very largely upon factors that have been set forth in an earlier paragraph.

PERCENTAGE OF HOSPITAL BEDS USED

In providing any community with an adequate number of hospital beds, it should be remembered that no hospital can reasonably be expected to have all but a few of its beds filled all of the time, unless it has an extremely flexible bed arrangement made possible by the use of private rooms or small wards. Many hospitals show only a 65 per cent use of their beds and

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few indeed can show over 85 per cent use, due in some measure to their inability to match the patients' needs with the type of facilities they have available. An annual average of 75 per cent is a reasonable showing over any measurable period of time. A certain number of beds are bound to stand unutilized. Rooms and wards must be renovated; not infrequently repairs are necessary. In some hospitals certain beds are definitely set aside for the detention of patients, particularly children, for periods of observation. It is well known that during the winter and spring months there is a greater demand for hospital service than during the summer and autumn. This results in a higher ratio of the use of beds during the first six months of the calendar year. It is during periods of epidemics and only occasionally during normal times that one may expect to find every bed in a hospital occupied. An unreasonably low percentage of occupancy is, of course, uneconomical and, if this is due to a lack of flexibility in the assignment of beds, every effort should be made to overcome it. In estimating the hospital needs of a community, therefore, one should not expect the percentage of utilization throughout the year to be more than 75 per cent.

PURPOSE OF SURVEY

The purpose and method of the survey itself may now be considered. The purpose of the survey which

we shall attempt to outline is not to determine primarily whether the existing hospitals of any community are doing the best work that can be expected of them, but, assuming that they are doing, or can be made to do, thoroughly efficient work, to determine what additional hospital facilities the community needs or whether the facilities which it proposes to provide meet a real need in the community or duplicate services already being efficiently rendered. In a word, its purpose is to assist those interested in the proposed project to clarify their minds as to the community's real need of a hospital, and, if the hospital is organized, to determine what its policy shall be.

The complicated conditions that prevail in some communities, particularly the community in which hospitals already exist, will often make it impossible to act fully and impartially upon the findings of a scientific study; but the study itself indicates that honest, conscientious effort was made to secure pertinent information basic to the building of an efficient hospital, the facilities of which, on the one hand, would not be found inadequate and, on the other hand, would not, so to speak, glut the hospital market with unnecessary beds.

FACTORS TO BE STUDIED

In surveying a community preliminary to the construction of a general hospital, the subject which would

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naturally be examined first is the facilities actually needed for general medical and surgical cases. In examining this phase of the problem, the first step is to make a study of the population of the community. This study should cover its growth or decline over a five-decade period as one, though by no means a conclusive, method of estimating the probable future growth or decline during the next five-decade period. Since this problem, as already indicated, is not one solely of size and growth of population, the character of the community's citizenship should also be studied from social, economic, industrial and religious angles. Such a study would enable one to make a fairly accurate estimate of the use that will be made of the hospital and show how to distribute its beds in wards, semi-private and private rooms. It is a well-known fact, for example, that certain foreign groups still stand in dread of hospitals and will not willingly go to them. They regard the hospital as a strange place, a place where they cannot get the food they are accustomed to, a place where people die. Ultimately education will lead even these, once they understand the advantages and purposes of the hospital to avail themselves of its facilities gladly and without fear. The use of interpreters and the provision of other agencies to promote a mutual understanding between immigrant patients and those who must deal with them and treat them, the adjustment of diets to meet the needs of special

groups, particularly in the large urban hospital, and the work and influence of social service departments, can all be used in educating the immigrant as to the hospital and its purpose, and in winning his good will.

FLEXIBILITY IN THE USE OF BEDS

In communities which have a relatively large proportion of poor people or people of small incomes, it is evident there will be more need for ward facilities than for private rooms. The presence of any large number of industrial plants points to the need of a larger proportion of beds for surgical cases, unless the industries themselves maintain their own first-aid and hospital departments. The community under consideration, for example, may be a mining community, a milling community or a farming community. Each has its own particular general hospital needs and some study should, therefore, be made of its industrial activities with special reference to the number and kind of industrial accidents and the number and kind of industrial diseases. Many accidents in some industries, as for example in coal mines, result in long-time surgical cases. Such situations would, therefore, call for emphasis on the male surgical service. Accidents in other industries may be largely of a minor character and would call for the installation of suitable outpatient departments. It should not be forgotten, however, that the hospital will be called upon from time to

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time to readjust itself to the demands made by changing social and industrial conditions, scientific discovery and community growth. Consideration such as the foregoing emphasize in a very pointed way the great desirability at the very outset of seeing to it that the plans of the hospital are flexible and can readily be adapted to new needs.

THE PREVALENCE OF SICKNESS

Having determined the size and character of a community's population, the next step is to give some consideration to the extent of sickness. When means and facilities exist, it would be desirable, though not absolutely necessary, to make an intensive study of the sickness that occurs in a specific period of time in the community as a whole or in carefully selected typical sections. If the latter method is adopted, fairly accurate figures for the community as a whole can be determined. If an intensive sickness study of the community in which the hospital is to be established does not seem advisable, recourse may be had with considerable advantage to information gathered by surveys in other communities. These studies quite uniformly show that on the average from 2 to 3 per cent of the population is constantly disabled. This percentage, applied to the population of any given community, will give the total number of people sick at any one time, exclusive of minor ailments and diseases that do not incapacitate.

SICK WHO REQUIRE HOSPITAL CARE

Having determined the number of sick people in any community, the next question to answer is how many of these will require hospital care. Some day we shall be able to determine with a greater degree of precision what diseases may be successfully treated at home and what diseases can best be treated in hospitals. Until that day arrives, however, we must use less precise methods of calculation. One way to approximate the number of sick requiring hospital care during a given period in a community which has no hospital, is to find out the number of patients sent from the community to available hospitals outside during that period. This can best be done either by personal visits to these hospitals, if the number is not too large, or by sending them questionnaires on which they are asked to indicate not only the number of patients, but also their address, the length of their stay and the general nature of their disease. Information thus secured should be supplemented by a survey of physicians' records and by personal visits to physicians to determine what additional patients would have been sent by them to a hospital during that period had one existed in the community. Moreover, conferences should by all means be had with the medical society of the community or with a committee appointed by it in regard to present hospital conditions and the community's present and future needs.

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HOSPITAL BEDS FOR SPECIAL DISEASES

Thus far we have dealt with the community hospital survey in so far as it relates to general medical and surgical needs. On occasion, however, it may be desirable to include in the survey, or have a separate survey made of the number of beds needed for special classes of cases such as obstetrical cases, contagious diseases other than tuberculosis, pulmonary tuberculosis, children's diseases, orthopedic cases, and eye, ear, nose and throat cases. The needs of the community with reference to the number of beds required for the various special types of diseases should be considered in the light of the experience of other communities. It would be well to look up the recorded judgment of leading authorities as to the ratio of beds to population for these special types. It is the judgment of one authority, for example, that to meet the needs of an urban community of 100,000 people there should be 50 beds for communicable diseases not including tuberculosis; one bed for each death from pulmonary tuberculosis per annum in the community, exclusive of the necessary provisions for the sanatorium care of early cases of the disease or for preventorium service for infants and children; 50 beds for children; 6 to 10 beds for operative orthopedic cases and from 10 to 20 beds for special eye, ear, nose and throat cases. In some communities even more beds will be needed to care for these special classes of cases.

CONSIDER PROBABLE FUTURE EXPANSION

In formulating the building program of the new hospital, it is important to remember not only the immediate needs, but also the probable future expansion, of the institution. This may make it desirable to build certain units of the hospital, such as the administration unit or the service building which usually houses the power plant, the laundry and possibly the morgue, larger than immediate needs demand. It will be desirable also so to plan the new structure that additions can be readily built for anticipated clinical expansion, whether that expansion be in the nature of a new department such as an eye, ear, nose and throat department, a contagious department or a department of psychiatry, or the enlargement of an existing department, due to a natural rate of growth.

THE HOSPITAL'S OUT-PATIENT DEPARTMENT

When it comes to a consideration of the different services of the hospital, a hundred and one questions arise. Do the needs of the community warrant the establishment of an out-patient department? If so, what service shall be included in the department? Can certain services use the same room at different times? How shall the patients be received and their histories taken? What provision shall be made for a social service department? What shall be the location,

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size and equipment of the clinical record room? Should it not be near the out-patient department? Shall the hospital have a medical library? If so, should it not be located near the clinical record room in order to enable the same person or persons to supervise both the clinical record room and the library?

In planning for the administrative needs of the hospital, consider the number and functions of the administrative heads; determine how the patients are to be received, registered and admitted, that is, whether both ward and private patients shall be admitted at one and the same entrance; the number and functions of the officers of the school for nursing, if the hospital is to have one; the number of other administrative officers for whom offices must be provided; what are the needs of the medical staff as regard a meeting or clinical conference room and registration room.

In planning the operating room consider such questions as these: What provision shall be made for a dressing and locker room for the staff; where shall the surgical dressings be sterilized; what and how much space shall be set aside for surgical supplies? Shall a separate room be provided for the administration of anesthetics? Is a recovery ward necessary?

ITEMS TO CONSIDER IN PROVIDING A LABORATORY

Of course the hospital will have a laboratory but what shall its size be and shall it have separate rooms

for pathology, bacteriology, serology and chemistry? How shall the house staff participate in the laboratory? Shall the hospital have departments of dentistry, radiology, electrocardiography, physiotherapy, occupational therapy and photography? If so, suitable provision must be made for each. Are the number of accidents which occur in the community such as to justify more than one accident room? Shall the living quarters of the superintendent be in the hospital or shall he have a cottage of his own? What rooms need to be provided for the resident medical staff? Shall a consultation and lounging room be provided for the visiting staff? What living quarters shall be provided on the premises for the domestic and other miscellaneous workers?

When considering the food service of the hospital, it will be well to raise these questions: Shall there be a centralized or a decentralized tray service? Shall there be a special diet kitchen for feeding cases? Where are the nurses to receive their instruction in dietetics—in the main kitchen or in the diet kitchen? What shall be the capacity of the various dining rooms?

QUESTIONS INVOLVED IN PLANNING THE LAUNDRY

Shall the hospital do its own laundry work? If so, where shall the laundry be located and what shall be its size? Does the hospital contemplate reclaiming used surgical dressing gauze? If so, adequate

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space must be provided to carry on this work. How much space shall be provided for sorting, distributing and storing laundry goods, as well as for sewing and mending them?

What provision shall be made for the care of patients' clothing?

Moreover, consideration should be given to the provision of adequate storage facilities. Altogether too many hospitals are hampered by the lack of sufficient storage space. It is far better to provide too much space than too little, for the additional space can always, if necessary, be used to good advantage for other purposes. The answer to the question of how much storage space to provide depends, of course, in part upon whether the hospital will produce its own light and power, and whether it uses coal or oil as fuel and whether the sources of supply of whatever fuel is used are reliable and readily accessible.

The foregoing considerations are a few of many that need to be considered in facing the construction of a new hospital building. It remains for a later volume in this series of handbooks, on the planning and building of the hospital, to elaborate these suggestions and to enter upon the discussion of many additional questions pertaining to such matters as heating, fire escapes, signal systems, incineration, refrigeration, illumination and a host of other subjects.

THE LOCATION OF THE HOSPITAL

Once the facilities needed have thus, with some degree of thoroughness, been ascertained, the next fundamental question is that of location. In the larger geographical and political units such as counties, the location of the hospital should not, of course, be determined by the desires of a particular individual to grace his little hamlet with a hospital that will stand as a monument to his folly or to the folly of the community whose laws or indifference allowed him to construct it; but by painstaking study of the topography of the geographical unit to be served, its size, its shape, its contour, its railway facilities, its public highways, the cost and time required to bring patients from various parts of the community to the hospital, the convenience of physicians, and the probable influence upon the number of patients of the larger, better equipped and better manned hospitals that are available outside of the community. Additional considerations that should be borne in mind in the selection of the actual site are the available light and air, the contour of the plot, the character of its soil and the utilities.

Barring exceptional cases, it is desirable to locate the new hospital a considerable distance from the city's business center, but invariably in or near the center of the residential district the hospital is organized to serve. This distance, however, should not be so great

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as to militate against the prompt delivery of supplies. Moreover, a hospital located within easy delivering distance of commercial storage facilities obviates the necessity of maintaining its own large storage rooms.

The question of whether or not the site of the hospital should be near a street car hinges somewhat upon the type of the hospital. If the hospital caters exclusively or largely to private pay patients, the question is of relatively less importance than in the case of free patients, since, generally speaking, patients and their relatives and friends will usually come by automobile. As most hospitals, however, have a considerable number of free or part-pay patients, accessibility to a street-car line is desirable. Because of the noise incident to running the street cars, it is well to locate a short distance from the car line, instead of directly on it. In selecting the site of a new hospital, it would be well to study the probable future development of the surface lines. The distance which the patients and their relatives and friends have to travel is not so important a factor as frequent service.

The relation of the site to the community's railway terminals calls for consideration. If the hospital expects to treat a considerable number of patients from other towns or cities, ease of transportation to and from the railway station is desirable. It would be well also to give some consideration to the usual condition of the roads for winter hauling from the railway

terminal. This consideration, however, applies more particularly to the larger hospitals.

The plot selected for the hospital should be large enough not only to give ample light and the free circulation of air irrespective of the structures that may be erected on adjacent properties, but also to allow for the institution's future normal expansion. Irreparable mistakes are constantly being made in the selection of sites that are too small. Hospitals are growing institutions and trustees who do not take this fact into consideration at the very outset in determining the size of the hospital's site are making a serious mistake. Should circumstances, however, make it utterly impossible to purchase as large a site as is desirable, then a careful study should be made of the height and sun-obstructing nature of the adjacent buildings. Simple cardboard models of these buildings, made to the same scale as the plan of the hospital and placed in relation thereto, will make it possible to come to an intelligent conclusion on this point.

If possible the shape of the lot might be such that the hospital when constructed on it will have a maximum of southern exposure. A lot with its long dimension running east and west has, as a rule, advantages over one the long dimension of which runs north and south. A site exposed to smoke from railroads and factories should not be chosen, nor should a dusty location be selected. If the latter, however, is unavoidable, a

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zone of trees, shrubs and lawn will do much to intercept the dust. Careful consideration should be given to the direction of the prevailing winds in dealing with the question of smoke and dust, both from outside sources and from the hospital's own stack. Data as to the prevailing winds of any given locality and as to the amount and velocity of wind from the various points of the compass over a given period of time, may be obtained from the United States Weather Bureau.

A site with a grade sloping gently toward the south makes for warmth, proper drainage and freedom from snow and ice in the winter. A site sloping to the north, or of irregular contour, should not be arbitrarily dismissed without any consideration of its adaptability to the program of the proposed hospital. Sometimes, indeed, an irregular site facilitates the development of a suitable plan. Now and again a site on the crest of a hill and sloping both north and south has very definite advantages, especially where a hospital of moderate or large size is contemplated. The site, therefore, should be selected on the basis of whether it is adapted to the program which the hospital plans to carry out and this study should be made by a qualified individual.

The soil should have excellent drainage and provide a substantial foundation. Before definitely deciding upon the site, pits should be sunk and test drills made if the character of the formation below ground is not

known. Should the soil be poor, the expense of constructing substantial foundations may be prohibitive.

It is highly important to look into the available utilities, their location and capacity. The location, quality and quantity of the water supply should be determined. If the water is taken from city mains their size and the pressure of the water should be ascertained. The location and capacity of the sewers should also be determined. Is their depth such as to serve the lower portions of the building? Similar information should also be secured as to storm sewers and other means of disposing of storm water. Needless to say, information should also be secured as to the availability and cost of electricity and gas.

TYPES OF HOSPITAL CONSTRUCTION

Another item that should be covered by the preliminary survey is the matter of type of construction. What are the best materials to use, having regard to their durability and cost and the climatic conditions under which they will be expected to stand up? Are the climate and other conditions such as to call for a hospital of one story or a hospital of more than one story? Should the hospital be housed in one building or several pavilions? What is the best and most efficient arrangement of the hospital in the light of the country in which it is to be built, the size and shape of the site, the service it will render and the convenience

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and comfort of the patients, doctors and nurses? It cannot be stated too emphatically, however, that boards of trustees should not formulate their ideas as to the best type of building for their purpose in any detail, as this is an architectural problem and can be successfully solved only after a careful study of the policy of the proposed hospital and of its service.

EMPLOYMENT OF EXPERT SOMETIMES DESIRABLE

In making a survey such as this, it would be well to seek the advice of those who are familiar with such surveys and, where the size of the problem justifies the expense, employ someone to conduct the survey who is thoroughly familiar with this type of work.

COST OF MAINTENANCE

Many are prone to forget, or at least to neglect to consider until too late, that after a hospital has been built it must not only be maintained, but also conducted so efficiently both from medical and administrative standpoints, as to commend itself to the public as a desirable place to go when hospital care is needed. It will be well, therefore, to consider carefully the cost of maintaining the proposed plant. To this end one should make a comparative study of the cost of maintenance of other hospitals of like size, not forgetting, of course, to add to, or subtract from, these figures as local conditions indicate.

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CHAPTER II

GETTING THE HOSPITAL ORGANIZATION UNDER WAY

ONE of the helpful ways in which hospitals may be classified is in their relation to the community in which they are located.

Thus classified they naturally fall into two main divisions, (a) public service hospitals and (b) proprietary hospitals. Into the former class fall all hospitals that receive patients as a public service, whether they are operated by a state, a county or a municipality, or by a corporation supported by private funds. Into the latter class fall all hospitals which are conducted as a private business for the profit of their owners.

In a discussion of the first steps to be taken in organizing a hospital, we shall arbitrarily refrain from any discussion of these steps as they apply both to proprietary hospitals and to public service hospitals under the control of the state or any of its sub-divisions, and limit ourselves to public service or community hospitals controlled and operated by corporations whose activities are supported largely by fees from patients

and private donations. The different steps that need to be taken in the organization of a public service or community hospital of this type are undoubtedly more varied than the preliminary measures that need to be taken in the organization of any of the other types to which reference has been made. Any discussion, therefore, of the steps that need to be taken in the organization of the former type will, in large measure, cover many of the steps that have to be taken in the organization of the latter.

CONDITIONS ASSUMED TO ESTABLISH POINT OF DEPARTURE

In order to establish a point of departure, let us start with a number of assumptions. Let us assume (*a*) that the community under consideration has no hospital; (*b*) that there is annually a sufficient number of sick people in the community needing hospital care to warrant the organization of a hospital; (*c*) that all cases of illness thus far have been cared for in the home, or, if very serious, have been sent to more or less distant hospitals, often at great expense and with occasional loss of life or permanent disability due to the lack of prompt treatment of a type which hospitals alone can afford; (*d*) that some one man—a physician perhaps—has a keen realization of the need of a hospital in the community, a realization deepened by the unnecessary death of a child or a wife, or, in the case of a physician, of repeated failures to obtain the end results which

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readily accessible hospital facilities alone make possible; (*e*) that this man lacks the funds with which to build a hospital of his own, or, having the funds, thinks that the hospital should not be privately owned, but should be supported and used by the community at large; (*f*) that the possibility of a hospital under state auspices is ruled out; (*g*) that the state has no enabling act permitting counties to start general hospitals; (*h*) that a municipally owned hospital is not desired, and (*i*) that a hospital under ecclesiastical or fraternal control is out of the question.

ENLISTING INTEREST OF INFLUENTIAL CITIZENS

What should this interested individual's first step be? Experience indicates that the wisest move to make is first to enlist the interest of a small group of influential citizens in the project. This may be done in one of several ways. His standing in the community may be such that he can make a direct approach to the individuals he wishes to interest. If he is not in a position to make a direct approach, he can do what one person did, place his conviction of the community's need of a hospital before the ministers of the community, the presidents of the chamber of commerce, the boosters' club and similar organizations, and gain their assistance in inviting five or six of the leading men of the community to a preliminary conference, at which the subject is approached tentatively. At this

meeting well authenticated facts may be presented that seem to point to the need of a hospital and what the presence of such an institution in the community will mean. Instances of flagrant lack of care may be cited, the prohibitive distance of the nearest available hospital, other communities of like size and type which have hospitals whose services have justified their existence. It should then be suggested that a detailed survey of the community be made as outlined in the previous chapter, partly to determine whether a hospital is really needed, but more especially where it should be located if built at all, what its size should be at the outset, what services it should render and the extent to which they should be rendered. The importance of this survey can hardly be overstated. To begin the movement without the basis of fact a survey will yield, would be extremely unwise.

DANGER OF ENTERING BUILDING PROGRAM HASTILY

Not a few hospitals are built that are not actually needed. They are constructed to satisfy some personal or group ambition, or before the community's needs have been thoroughly studied. Often charitably inclined individuals with money will construct a hospital as a memorial, quite regardless of the community's needs and often without an endowment fund to maintain it. The result is that many hospitals are too small and too weak financially to employ efficient superin-

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tendents and to purchase the equipment needed for thoroughly modern service. Furthermore, many are not planned to render the kind and diversity of service an intelligent, impartial survey would show were urgently needed, while others are wrongly located in relation to the community's present needs and probable future growth. These statements should not be interpreted to mean that small hospitals should not be built when a thorough-going and unbiased survey shows they are actually needed, but rather that a building program should not be entered upon hastily and blindly, but only after a thorough consideration of all the factors involved, including not only present necessities but also probable future demands.

AUTHORIZING AND FINANCING SURVEY

The question naturally arises at this point as to who shall authorize this survey and, if an expert needs to be employed, who shall assume financial responsibility for his fee and expenses. The survey may very properly be authorized and financed by one or all of the organizations whose representatives are present at the preliminary conference, or, if the representatives themselves are persons of means, one of them, impressed with the wisdom of having the survey made, may be willing to meet the entire expense, or all of the representatives may agree to stand the expense on a pro-rata basis. If it is felt that the expense should be

borne by the organizations represented, it will be arranged to have the representatives in attendance at the preliminary meeting bring the matter to the attention of their respective organizations for suitable action. The representatives may very well be constituted a temporary joint committee to handle the funds needed for the survey, engage the expert, receive his report, report back to the organizations interested and in a general way be responsible for the survey.

PRE-ORGANIZATION, OR CITIZENS', COMMITTEE

If the findings of the survey prove conclusively that the community, whether it be a rural community or a section of a city, needs a hospital of a given size, rendering certain well-defined services, then the time has arrived for the definite formation of a pre-organization, or citizens', committee who will sponsor the project and carry it to a successful conclusion. Selecting the personnel of this committee is an exceedingly important piece of business, for the success or failure of the undertaking hinges very largely upon this selection. There is this additional reason for care in the selection of a pre-organization committee: in the later organization of the hospital association, some, if not all, of the members of the original committee will probably be elected officers and trustees of the association. This follows almost inevitably. The failure of several hospital projects is to our certain knowledge due to serious

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mistakes made at this point. In one instance where an unsuccessful attempt was made to establish a hospital intended to serve three or four more or less distinct communities, the mistake was made of asking the physicians in each of the several communities to appoint representatives on the citizens' committee. Lacking the judgment necessary for wise selections, the representatives thus chosen were ill suited to the task in mind and the movement ended in a fiasco. The wiser plan is to have the pre-organization committee selected by the small group of men originally interested in the movement or by the president or the executive committee of the local chamber of commerce or some similar civic body. The utmost care must be exercised to see that men and women of personal worth are placed on this committee, men and women who have no personal axe to grind, who will work in harmony and further the best interests of the institution, men and women who represent a variety of interests, financial, industrial and professional, and who are at the same time public-spirited and willing to give a reasonable amount of time and effort to the project. It need hardly be stated here that in a community venture of this character every effort should be made to avoid ecclesiastical and political entanglements, as well as all personal and group jealousies and ambitions. Clearly they have no place in a movement intended to promote the interest of the community as a whole.

THE FIRST MEETING OF THE CITIZENS' COMMITTEE

After the members of the pre-organization committee are selected and their consent to serve has been secured, they should be called together to organize themselves into a working body. This call may be issued by the president of the chamber of commerce or by the small group of citizens which had a hand in selecting them. Whether this is a luncheon, a formal dinner meeting or a late afternoon or evening meeting will, of course, depend somewhat upon the custom of the community and the membership of the committee. It would seem desirable, however, to make this meeting something more than merely a formal business meeting for the election of officers and the appointment of committees. Enough time might well be set aside for this meeting to afford an opportunity for the exchange of good fellowship and for beginning the development of an *esprit de corps* that will grow as the movement progresses. If possible, it would seem desirable, therefore, to make this a dinner meeting and to devote part of the evening not only to the election of officers and the appointment of committees, but also to a presentation in some detail of the project for which the committee was organized.

PRESENTING RESULTS OF SURVEY

In selecting the place of meeting care should be taken to select one where the committee can meet on common

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ground—the chamber of commerce, the community center, a hotel, perhaps. Scrupulously avoid giving the impression that the project is the project of any single group or section of the community. After the dinner, the temporary chairman, who has been chosen because he is the clearest thinker and ablest speaker in the group, and has made a thorough study of the findings of the survey, will explain in broad terms the purpose of calling the committee together, and place before them exactly what is revealed by the survey as to the community's need of a hospital and what it is proposed shall be done to secure one. Three or four well-prepared charts will add to the interest of the talk. These might show graphically the number of persons who were sick in a given period of time, what proportion were cared for in their own homes, what proportion were taken to distant hospitals and what proportion could and should have had hospital care, were a hospital in the community. Another chart might show the adequacy or inadequacy of the care hitherto secured by the sick of the community.

ORGANIZING THE CITIZENS' COMMITTEE

It might be well to have the speech of the chairman followed by two or three brief prearranged discussions, followed by general discussion and the answering of questions. At the conclusion of the discussion the chairman will suggest that the committee elect its

officers and provide for an executive committee to consist of the officers and the chairmen of the various committees to be appointed later by the president, and for the appointment of committees on publicity, finance and membership, name, constitution and by-laws, and nominations. It would be well if the original make-up of these committees were such as to enable the president to appoint at least one person on the publicity committee who is connected with one of the local newspapers or has had some experience in publicity work, a banker or successful manufacturer on the finance committee, and a lawyer on the committee on constitution and by-laws. The latter will also be helpful in drafting subscription blanks and the articles of incorporation in proper legal form, and in attending to the matter of securing a charter.

APPOINTMENT OF NOMINATING COMMITTEE

It is extremely important that the president should exercise care in the appointment of the nominating committee. Members of this committee should be thoroughly conversant with the various interests of the community and, so far as is consistent with the efficient administration of the institution, place in nomination officers and trustees who will give a well-rounded representation to the various interests of the community whose co-operation is essential to the success of the institution.

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OUTLINING THE PROJECT AT VARIOUS MEETINGS

As a means of awakening the interests of the community in the proposed hospital, it has been found helpful to outline the project at meetings of the women's club, the women's improvement association, if there be one, and the merchants' association, as well as to hold one or two mass meetings at which prominent outside hospital executives and physicians speak, and at which the findings of the survey are presented to the public. The time and place of these meetings should be conspicuously announced in the local papers, and by letter to those who through subscription or otherwise have indicated a special interest in the project.

At one of these meetings, which may very appropriately be presided over by the mayor of the town or the president of the board of supervisors, if in a village or rural community, a hospital association should be created on the motion, let us say, of the chairman of the pre-organization committee, or of the committee on constitution and by-laws. This piece of business should, of course, be arranged for in advance of the meeting.

Since the institution is to be a community hospital, it will probably be wise to allow all in attendance at the meeting to vote on the proposition of organizing the hospital, adopting its constitution and by-laws and electing its officers.

ADOPTION OF CONSTITUTION AND BY-LAWS

The resolution calling for the organization of the hospital having been adopted, the meeting should then proceed to the adoption of the constitution and by-laws, article by article.¹

ELECTION OF FIRST OFFICERS

It will be next in order to receive the report of the nominating committee and, according to the provisions of the constitution just adopted, to proceed to the election of officers and trustees. It might be well to provide in this constitution that the number of trustees elected in any one year shall not be so large as to destroy the policies that have been agreed upon and found to work well elsewhere. If the board of trustees, for example, is to be made up of twelve members, one group of four should be elected for one year, a second group of four for two years and a third for three years. With the election of officers and trustees, the meeting will stand adjourned, subject to the call of the president whose responsibility it will be to request the secretary to send out further notices of meetings from time to time as the exigencies of the situation and the development of the hospital dictate.

¹ For examples of constitutions and by-laws see Appendix, pages 145-165.

IMPORTANT TASKS CALLING FOR EARLY ACTION

There are five important tasks which the officers of the association should attend to promptly: First, to formulate the association's articles of incorporation; second, to apply through the secretary of the association for a charter; third, to enter into a definite agreement between the association and a hospital architect for planning and supervising the construction of the hospital; fourth, to appoint the standing committees of the board, such as executive, site and buildings, finance, constitution, audit, publicity, and nursing school, if the hospital is to have a school; fifth, to establish and announce the temporary headquarters of the association. This may be located in the office of the president or of the secretary. If the project is large enough, a separate office may be opened or space may be donated by the community center or the chamber of commerce for this purpose.

After the hospital is built and equipped, some alteration may be made in this roster of committees; the committee on site and buildings, for example, may be made the committee on house and grounds; or, if the institution is large enough, the committee may, as in the case of many large institutions, be divided into two committees, one on house and one on grounds.

These activities will be considered at greater length in the next chapter.

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CHAPTER III

DUTIES AND RESPONSIBILITIES OF THE BOARD OF TRUSTEES IN PRELIMINARY ORGANIZATION

THE initiation, development and guidance of hospital policies today is a matter of extreme importance and calls for a high order of ability. In the modern hospital we recognize some type of governing board as the supreme and responsible body. Hence, at this point in the development of the community hospital, careful thought must be given to the organization of a governing board which, in the last analysis, must assume full and final responsibility for everything connected with the institution it controls. A group of individuals in the community must therefore be selected who have the personality and are otherwise qualified to serve in this capacity and who are willing to give the necessary amount of time, thought and energy to the hospital without remuneration, emolument or gain of any kind.

The hospital association formed for the preliminary development of the plans and policies of the organization as outlined in the previous chapter will determine the type of governing board to be selected and the

method of its selection. This must be a coöperative group which has more detailed information about the institution and its ideals than any other persons in the community with the exception of the superintendent and the medical staff. This board, and its standing committees, should meet regularly. It must be so organized as to oversee in a general way the work of the hospital's executive personnel as they carry out its policies and deal with all matters that should properly come to its attention in the operation of the hospital.

CHOICE OF NAME FOR GOVERNING BOARD

A governing board may be called by any one of a number of different names in use today, such as directors, trustees, commissioners, or hospital trust. These terms serve their purpose in a more or less satisfactory way. But from an analysis of the terms from a purely etymological standpoint, different interpretations may easily be reached. The term "board of trustees" implies a trust or responsibility to be carried. The duties of the governing board, if conscientiously performed, cannot but be regarded as a trust or responsibility. In no other field probably does this apply so forcibly as in hospitals, where persons are dealing constantly with matters of life and death. The term "board of directors" is used very extensively. It may, however, readily lead to confusion. When used as the title of the hospital's chief executive officers or as the

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title of heads of departments, it carries etymologically, a meaning quite different from the term "trustees." "Hospital commission" is a term usually applied to an elected group, especially in connection with a municipal, state or federal institution whose members are elected directly or indirectly by vote of the people. The name "hospital trust" is occasionally used in connection with an endowed institution, where a very small group is concerned with its welfare and is charged with the responsibility of handling the endowment. As such, it controls the institution. However, it is not necessary to spend too much time in debating the relative merits of different terms, since it is one of the least important of the problems in which we are immediately interested. In selecting a name for the governing board, however, it is well to select one which conveys the most evident and intelligible idea of its functions.

In organizing the governing board of any institution, three things must be considered: First, limitation of numbers; second, qualifications; third, methods of selection.

SIZE OF GOVERNING BOARD

What shall be the size of the governing board? Advocates of large boards of trustees contend that small boards are not thoroughly representative and tend to become autocratic. Advocates of small boards,

on the other hand, contend that large boards are too cumbersome, too diversified in their thought and judgment, making it difficult to come to well-defined conclusions, and to obtain a reasonably good attendance at meetings. While the governing board of a hospital should be neither too large nor too small, it seems undesirable on the whole to indicate any arbitrary limits, although experience seems to indicate that in most instances a governing board can function best when its membership is relatively small. Nevertheless, instances may readily be cited of boards of thirty and even forty members which, under capable leadership, accomplished more than a smaller board would be likely to accomplish. It depends very largely on the personnel of the board. Rapid changes in the membership of the board are, of course, not desirable; a certain percentage of the membership should retire annually with the privilege of re-election, simply to give the members of the hospital association an opportunity to express their opinions. If but one third of the board retires, the basic policies of the hospital will not be materially affected.

QUALIFICATION OF GOVERNING BOARD MEMBERS

The question of the qualifications of the members of the board is an extremely important matter and has not, as a rule, received as much attention as it should. There are a few fundamental principles that have

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a pertinent bearing on the members of the governing board of any hospital. They should have a genuine interest in the welfare of their community. They should command the respect and confidence of their fellow citizens. They must be prepared to give their time freely. They must have the analytical mind of a judge, balanced by patience, sympathy, broad-mindedness and fairness, if they are to guide the affairs of the institution wisely.

In selecting a governing board for a hospital, an effort should be made to select persons whose interests are diversified so that varied talents may be used in guiding the work of the institution. A good newspaper man is desirable because a hospital needs well-guided and compelling publicity. A lawyer can frequently assist by passing upon legal matters that come up for attention. An educator, such as the president of a university, the principal of a normal college or high school, makes a valuable addition to any board, for the hospital must be a teaching institution throughout, especially in the education of internes and pupil nurses. The president, or one of the other officers of the local chamber of commerce, or an officer of one of the community service clubs, should also be on this board. The board, however, should not contain any member of the active or consultant medical staff of the hospital. In short, the members of the board should be selected from groups representing

financial, administrative, educational and other broad public interests.

METHOD OF SELECTING GOVERNING BOARD

The board of trustees of a hospital should be representative of the interests behind it. The method of selecting the trustees varies considerably with the type of institution, depending upon whether it is a community hospital, a municipal, county or state institution or a hospital under ecclesiastical or fraternal auspices. A community hospital is the outcome of the representative action of the citizens at large. They must choose their own board of trustees. An excellent method is to select them on the basis of their contributing interest.

Having selected the personnel of the board in keeping with the provisions of the constitution, the next step is to organize the board, choose its officers and appoint various working committees. A rule which will call the board together within twenty-four hours after their election to office for purpose of organization is advisable. The constitution should authorize the secretary, or some officer of the corporation, to call this meeting, arranging a suitable time and place. After the meeting has been called to order, its temporary chairman will ask for nominations for the permanent chairman or president. Voting by ballot is desirable. As soon as the permanent chairman has been

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elected, he will take the chair and the board will then proceed with the election of the other officers. There should be a vice-president, a secretary, a treasurer, or a secretary-treasurer. If there is a paid secretary, the board appointee, if one is necessary, should be an honorary secretary.

WORKING COMMITTEES

Once the president of the board has been elected, the selection of the working committees is usually left to him. Committees of the board of trustees are of two kinds: first, committees which hold their position during the entire year and are known as "standing committees"; second, committees which are appointed from time to time for a special purpose and are called "special committees." In this chapter we shall concern ourselves mainly with the former, or standing, committees. It will usually be found desirable to appoint the following working committees:

- (1) An executive committee, consisting of the president, the vice-president, the secretary, and the treasurer, who will act on behalf of the board between its meetings and may be called upon short notice to deal with matters of particular urgency. This committee, of course, is formed automatically with the appointment of the officers of the board.

- (2) A house committee, consisting of six or seven members who will take particular pains to educate

themselves regarding the internal affairs of the institution. The house committee will meet at least monthly and consider matters upon which the superintendent requires advice. Matters of serious discipline, authority for the expenditure of relatively large sums of money, the development of the various departments of the institution, and other appropriate matters should come before them at their regular meeting.

(3) A carefully selected finance committee who will deal with the financial policy of the hospital, initiate methods for raising revenue, pass on the budget, on investments and on other matters properly coming under its jurisdiction. This committee should consist of four or five members.

(4) A building committee when new buildings are under construction or old ones are being remodeled. This is an extremely important committee. For this reason it should consist of men who have some practical knowledge of construction. Four or five members are sufficient for such a committee.

(5) A school of nursing, or educational committee. Every hospital having a school of nursing should have such a committee to consist of three or four members of the board and three or four educators, if the latter are available. The committee should deal with all matters pertaining to the school, such as the curriculum, method of teaching, standards, lectures, etc., but

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not with discipline. Discipline rests with the superintendent, or with the director of the school of nursing, coöperating with the house committee, if necessary.

In the appointment of committees two things should be kept in mind: First, to find a place on some committee for every member of the board; second, to place each member of the board on the committee which will give him the widest scope for the exercise of his talents.

The committees should be left to select their own chairmen. This, again, is a vital matter, for the chairman of a committee often determines the character and amount of work the committee accomplishes. The chairman of the house committee, for instance, should be a man of sound judgment, pleasing personality, cool, patient, deliberate and a very wise counsellor, for he will frequently be consulted by the troubled administrator. This individual also gets such a splendid schooling in hospital administration that it not infrequently will enable him later to hold the chairmanship of the board. The chairman of the finance committee should preferably be a banker or the manager of some large corporation. The chairman of the school of nursing, or educational committee should be an educator or a university graduate.

The superintendent of the hospital and the secretary of the board are ex-officio members of every committee and should be present at all board and committee

meetings. The director, or superintendent, of nursing, the secretary of the board and the superintendent of the hospital should be ex-officio members of the school of nursing, or educational committee.

The purpose of these committees is to give particular thought to their respective departments so as to be in a position to present their problems to the board in a well-thought-out, concise form in order to save the board's time when faced, as they frequently are, by a long agenda at each monthly meeting. Committees do not, as a rule, have complete authority and power to act. This may be given occasionally, but guardedly, and only by resolution of the board. Frequently an almost finished piece of business may be safely left in the hands of a committee with so-called "full power to act."

TIME AND PLACE OF MEETINGS

Committees should have a fixed time to meet. Let us suggest, for example, the following schedule of meetings: The school of nursing, or educational committee, the first Thursday; the house committee, the second Thursday; the building and finance committee, the third Thursday; the board, the fourth Thursday of every month; the executive committee, always at the call of the chair.

The committees should have a regular place in which to meet and a definite hour, say 8 P.M. sharp.

FILING ARTICLES OF INCORPORATION

The first duty of the new board is to formulate and file articles of incorporation, so that the hospital may become a duly organized body with power and authority to act.¹ The articles of incorporation should set forth the scope and purposes of the organization. This procedure varies in different states and provinces. Consequently the board should delegate this duty to the secretary and a committee, who will carry on their negotiations through a capable lawyer. The legal aspects of the matter will thus be properly safeguarded. In some states the secretary of state is authorized to issue charters to hospitals under a general law pertaining to non-profit-making corporations. In other states charters are granted by special acts of the legislature.² Having filed articles of incorporation and secured the charter, the board of trustees is now ready to develop the affairs of the hospital.

SELECTING TEMPORARY HEADQUARTERS

Not having as yet a hospital building in which to meet, temporary headquarters for the hospital association must be established. In doing this, convenience of location should be taken into consideration.

¹ An example of articles of incorporation will be found on page 131 of the Appendix.

² An example of a charter will be found on page 135 of the Appendix.

Frequently space in a downtown office building will answer, especially when a financial campaign is to be conducted. In the latter case, the most desirable location is a spacious, street-level accommodation in the busiest street in the city where the largest number of people may have an opportunity to become acquainted with the project. An attractive, well-arranged office, with pictures and literature available to rivet attention, is advisable. This should be the headquarters of the hospital until such a time as the institution has its own building. Not infrequently a vacated store with good plate-glass windows makes an excellent headquarters for campaign purposes. This, however, is a matter to be considered in relation to the particular case; but one of the factors that must ever be kept in mind during the developing stages of a hospital, and indeed always, is publicity.

SELECTING THE ARCHITECT

Before the funds necessary to construct the hospital can be raised and the project gotten under way, a preliminary sketch and a rough estimate of the cost of the new hospital must be prepared for use in the financial campaign. To this end the architect should be appointed very early in the development of the project. So vital is the part played by him in the planning and construction of the hospital, and so great is the influence of his work on the future management and effi-

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ciency of the institution, that something must needs be said here as to his selection, his qualifications and his services.

QUALIFICATIONS OF THE HOSPITAL ARCHITECT

It need hardly be pointed out that the architect who undertakes the planning of a hospital must have a keen imagination and be a student of human nature, not only as it is found under normal conditions of health but also under the stress of sickness. Moreover, he must be familiar with the feelings and desires of the various groups who come to live and work in the institution, including the patients, the doctors, the nurses, as well as the lay workers and other professional groups. Furthermore, he must be thoroughly familiar with the technique of the hospital and be able to explain the operation of any plan he may devise.

But the successful planning of a hospital demands more than this. It demands a thorough knowledge of structural, mechanical, sanitary and electrical engineering, of architectural design and of sound business principles, not to mention a complete knowledge of the technique of the hospital and the progressive steps required to render thoroughly efficient service. It does not lie within the power of any one man to be an expert in all these lines. Consequently, the efficient planning of a hospital calls for an organization of men who are experts in these various branches of the science and

art of building, so integrated that any hospital it may plan will embody the most effective principles in each branch of the work.

ARCHITECT MUST UNDERSTAND OPERATION OF HOSPITAL

The first task of the architect, as already indicated, is to prepare a preliminary sketch of the proposed hospital, and a rough estimate of its cost for the use of the trustees in raising funds needed to build the structure. In the preparation of these preliminary studies, the architect will avail himself of the data collected in the preliminary survey of the community, to which extended reference was made in Chapter I, or, if such a survey has not been made, conduct one of his own, collecting and compiling whatever data may be pertinent to an understanding of his client's problem. He must, of course, understand the business of running a hospital so thoroughly that during these preliminary conferences he can bring out his client's ideas by a series of intelligent questions. This can scarcely be done in half an hour's interview.

After the financial campaign to raise funds for constructing the new hospital is completed and the trustees knew exactly how much money they can expend, the architect may be called upon to modify, re-draw and elaborate the preliminary sketches, until both the hospital trustees and the architect are convinced that a satisfactory solution of the problem, with due regard

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to the funds available, has been found. These revised sketches should, of course, conform to well-established principles of planning and call for the combined judgment of the expert designer and the various engineers. They should show the relative location and size of all the parts of the building in such a way that the building committee will have no difficulty in understanding them. It is the architect's duty to convey to the building committee a true mental picture of the structure he plans to erect. These sketches should embody the result of the architect's experience, reinforced by careful study and analysis of the problem under consideration.

DOCUMENTS TO BE DEVELOPED BY ARCHITECT

After the board of trustees has finally approved the sketches, the architect prepares the working drawings and specifications as follows:

(1) *The general drawings*: These illustrate the exact physical arrangement of the building and give the details of construction and fabrication required for the various parts. They should show the different kinds of materials, their extent and how they are related to each other, thereby eliminating guesswork on the part of the contractors.

(2) *The structural drawings*: These show the structural members, their dimensions and sizes.

(3) *The mechanical diagrams*: These illustrate the

arrangement, location and sizes of all pipe work, ducts, fittings and valves necessary for heating, ventilating, plumbing, wiring, sprinklers, vacuum, compressed air and other services, including machinery and equipment layouts.

Sometimes the data contained in (1), (2) and (3) are combined in a single set of drawings.

(4) *The specifications:* These clearly describe all the materials and workmanship, written in such a way that fair competition is obtained. The practice of some architects of specifying manufacturers' catalogue numbers bespeaks laziness and may involve the hospital in additional expense.

(5) *The details:* These are additional drawings made on a larger scale and are furnished for the guidance of workers on the building. They are part of the architect's services and there is scarcely a hospital that does not call for them. If the contractor supplies them, the hospital is paying for them twice.

Should the architect fail to supply any of the above documents or information, the contractors submitting figures on the building are obliged to include a price for architectural service or do some of the work by guess; in either case the hospital pays dearly.

The next step is to obtain proposals from the contractors. Here the experienced architect is needed, as there are so many loopholes and tricks of the trade that a hospital may be shamefully fleeced in the

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absence of good business methods. If the hospital desires competitive bids, its architect usually prepares a list of available contractors after he has carefully examined their ability, financial responsibility and reputation. Once the hospital has selected its contractor, the architect usually feels relieved of responsibility in this connection. If, however, the architect feels that the contractor selected is unsuitable, he will, if conscientious, report his objections to the hospital.

The hospital's building committee should be present at the opening of all bids and make its award to the most desirable bidder. The architect's services include the preparation of the necessary contract documents, drawn to protect the owner's interest.

INVESTIGATION AND SUPERVISION

The building committee has a right to look to the various experts who created the building to supervise its erection. The contractor can scarcely be left to his own devices.

An accurate account of the progress of the work must be kept in order to protect the hospital's funds. The system proposed by the architect should be carefully examined and detailed reports insisted upon.

In selecting its architectural service, the hospital should insist upon knowing the details of the organization it contemplates employing, including the experts and the way they handle their work. It should deter-

mine whether the architect's organization is business-like, whether the various members have had adequate experience in their line of work, and whether they are really equipped to give a complete service.

The reputation of the architect should be ascertained. References should be secured and consulted.

Are the architects interested in hospital planning and construction, or do they merely want the job for the commission? Will they look after the hospital's interests and give it the necessary coöperation? Will the hospital secure the personal services of the architects themselves rather than of their underlings? Architecture is a profession, and the organization that turns its services out as a factory turns out goods should be studiously avoided.

In instances where hospitals employ architects who do not have engineers on their staff, it would be well for the hospital to insist that they employ the services of a consulting engineer. The advantages of such an arrangement are many. Based upon a careful study of the type, location, use, etc., of the hospital, the engineer decides upon the nature of the systems of equipment to be installed, calculates parts and sizes and prepares working and detail drawings and specifications. He issues information to the contractors regarding the installment of the equipment and supervises the work carefully. This supervision includes the inspection and, when necessary, the testing of mate-

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rials. He also sees that the contractor meets all the provisions of his contract and examines and reports on all bills. When the hospital is placed in operation he gives it expert supervision. This is, of course, the time when adjustments invariably need to be made and employees familiarized with the entire system of equipment. His services ensure complete installment of equipment according to specifications, prevent unjust charges and obtain proper allowances. It avoids the difficulties incident to incomplete plans and specifications and the injustice of asking contractors to bid on work, the plans and specifications for which have been prepared by another contractor or by a manufacturer. It ensures skilled workmanship and the use of specified material, because work and materials are accepted only on the approval of a disinterested expert. It saves the architects and owners a great deal of time and responsibility. In short, it makes for a low first cost, low operating expense and durability.

SERVICES OF HOSPITAL CONSULTANT

If the architect the board desires to select is not thoroughly conversant with the activities carried on in a hospital, it would be well to augment his services with the services of a consultant who, in most instances, will be the individual who makes the original survey as indicated in Chapter I. Trustees usually need advice as to what their hospital should be, the

services they should incorporate, especially in view of the services rendered by other hospitals, the relative number of beds, how the hospital should be organized to carry out its primary purpose, how the building should be planned to render it best adapted to the program which the trustees adopt and how the most essential things can be provided within the limits of the hospital's funds. It is exceedingly difficult for a board of trustees unaided to answer these questions wisely and there are relatively few architects who have had a broad enough contact with the hospital problem to give material assistance to boards of trustees.

Seldom will the funds at an institution's command permit the building of a hospital as complete as might be desired. Some features must be eliminated, and it is seldom that an architect is sufficiently informed on hospital procedure to know what features can best be eliminated or abridged. On the other hand, a consultant who has had long experience in the actual administration of hospitals, and has made a thorough-going study of many plans, is better able to adjust the plans of the proposed hospital not only to the fundamental policy adopted but to the available funds. Moreover, a consultant with a knowledge of the accurate adjustment of spaces to services to be performed in those spaces, is likely to be much more economical in planning than the average architect who lacks this knowledge.

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The medical board if organized should be given a hearing in the planning of the hospital. It is to be expected, of course, that the views of individual members of the medical board in regard to the planning of the hospital may conflict with one another, and the views of some may have to be modified in the interests of the project as a whole. Under tactful leadership, however, it should be possible to reconcile conflicting opinions readily.

Although the superintendent should be employed at an early stage in the development of the new hospital, his advice cannot always be wisely accepted, since his knowledge and experience are likely to be limited to one institution, or at best to only a few institutions. The consultant, on the other hand, renders advice based on his successes and failures in the planning of a large number of hospitals.

It is altogether desirable, therefore, that boards of trustees should employ a competent consultant to aid in the preparation of a building program, the consultant to advise, coöperate with and assist the architect in the preparation of plans and specifications.

CALL CONSULTANT AT EARLY STAGE OF DEVELOPMENT

As the hospital's program is the basic consideration and the plans represent, or ought to represent, the application of recognized principles to the particular hospital in hand, the consultant should be called in at

the earliest possible stage in the development of the institution.

The responsibility of the consultant should cease upon completion and acceptance of the final plans and specifications, as the duty of supervising the construction of the building should be left in the hands of the architect or engineer. Some consultants, however, include in their contract with the hospital a provision which gives them broad supervisory powers over the administration of the new plant for a definite period of time ranging from six months to one year.

The relatively small expense involved in obtaining the services of a competent consultant represents so insignificant a part of the annual cost of overcoming the handicaps of a poorly planned institution, due to an incomplete study of the hospital's needs, that boards of trustees should consistently avail themselves of the knowledge, experience and breadth of vision properly qualified consultants are in a position to bring to bear on the problem in hand. Extreme care, however, should be exercised in selecting the consultant to see that he is the expert he claims to be and is capable of doing good team work with the architect, so that the hospital may not suffer from a divided responsibility.

EARLY SELECTION OF SUPERINTENDENT

The early selection of the superintendent of the hospital is advisable because of the technical knowledge

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which he or she brings to the development of the plan. The superintendent of the hospital, therefore, should be selected before the plans are finished and the building commenced. His knowledge and experience in such technical hospital matters as will arise must not infrequently be available in order to prevent errors in judgment.

Choosing a superintendent is an extremely difficult matter. Thus far little has been done toward the systematic training of hospital superintendents. It is true that the hospital administrator of today has the advantage of having at his command several monthly journals devoted to the hospital field. He may also attend state, provincial or national hospital meetings at which he can secure theoretical and practical information of great value. Moreover, he has at his command the services of The Hospital Library and Service Bureau with headquarters in Chicago, Ill. Nevertheless, it remains true that, generally speaking, the hospital superintendent of today has had to gain his knowledge and skill in the hard school of experience.

In selecting a superintendent, the hospital should seek the superintendent rather than the superintendent the hospital. The hospital presumably knows best the type of person required to manage its affairs, and in any event it can always obtain advice on this matter from other hospital officials of longer experience. Securing a superintendent for a hospital which is in

process of development is a much more important and serious matter than securing a superintendent for an already fully organized and successfully running institution, for the superintendent of the new institution will have to do a lot of pioneer work and at all times be prepared to give expert information on the organization and equipment as well as on the construction of the hospital.

The superintendent should preferably be a person of experience and training in this particular field. He should, moreover, inspire confidence and good-will in his entire staff, medical and lay. He must be diplomatic and have an abundance of patience and sympathy. He must possess good judgment and act with decision. Individuals who cannot meet these requirements should not be encouraged to go into hospital administration.

TECHNICAL KNOWLEDGE OF SUPERINTENDENT

As the superintendent of a new hospital, one of his first tasks will be to select the institution's equipment. He must therefore have a thorough knowledge of equipment. Lacking this knowledge, he runs the danger of buying the wrong things or buying what later will not be needed. A blueprint of the proposed hospital on which all the required equipment has been plotted will be of invaluable assistance in making purchases.

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Since the institution exists primarily for the medical treatment of its patients, the hospital superintendent must have a certain knowledge of medicine. Whether or not he should possess a medical degree is a question which we cannot argue here. He should, however, have sufficient knowledge of medicine to give him easy access to the physician in the intelligent discussion of administrative medical problems. In short, he must know the bearing of the general principles of medicine on the administration of his institution and he must know when proper service is being rendered to the doctor and the patient. He should inform himself as to the real value of the work done in the hospital through a monthly analysis sheet.

A knowledge of institutional sanitation, public health and hygiene is fundamental. For it is his duty to see that proper sanitary conditions prevail throughout his institution. He should have knowledge of the best administrative procedure to follow in dealing with contagious diseases.

Frequently we find the community is not thoroughly familiar with the hospital, and community relations are lacking. The successful superintendent will always bear in mind the inestimable value of maintaining good community relations, and be constantly on the lookout to establish and maintain them. All-around coöperation with allied bodies such as the state and county medical societies, the nursing associations, the

public health department, and the various philanthropic and civic agencies of the community is very essential.

SUPERINTENDENT SHOULD SUPERVISE CONSTRUCTION

While the construction of the new building will go forward under the guiding eye of the architect and foreman of works, it should also be supervised by the superintendent. Consequently the more knowledge he possesses about the construction of hospitals the better. For, in spite of the most careful study and planning, it is often found desirable to make some changes during the process of construction, and at any rate, the superintendent will be better able to maintain the building if he knows the material of which it is built and the method of its construction. In this connection, it need hardly be said that while the principle of not altering the plans, once they have been accepted by the trustees of the hospital, should be adhered to, yet an occasional change may be necessary in the interest of efficiency.

Equipping the hospital, as already mentioned, is an important task. Equipment today is changing rapidly and a great variety of many articles may be found on the market. Some equipment is good; some, poor. A definite study should be made of what the hospital needs and what equipment will best meet those needs. Of course, the amount of money available

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will have some bearing on the quantity and quality of the equipment secured.

CHOOSING THE MEDICAL STAFF

The next problem confronting the hospital—choosing the medical staff—is, generally speaking, not altogether an easy one. If there is only a limited number of doctors in the community, the task is a relatively easy one, but if there is a large number, it is an extremely difficult one. The hospital movement today demands that only qualified and ethical doctors shall be allowed to practice in hospitals. Now that the courts are holding boards of trustees responsible for the care of the patient, the time has come when the medical staffs of institutions must be carefully selected. The size of the staff and the number of services must be authorized by the board. This depends somewhat on the size and the program of the institution. As the hospital under consideration is a new one, the board of trustees will have to take the initiative in selecting the medical staff. In the performance of this task it may look to some of the leading physicians and surgeons of the community for advice and specific recommendations. In every instance, however, the individuals chosen should meet certain clearly stipulated qualifications as to scholarship and ethics.

All the members of the staff and the chiefs of the services and assistants should be appointed for a term,

say, of from one to five years, and the appointments should be renewable at the expiration of the period. There are definite advantages in having the terms of the chiefs and assistants expire at different times. While the board of trustees controls the appointment of the medical staff, it will be desirable in most instances for the board to consult the superintendent relative to appointments and obtain the benefit of his judgment before they are officially made and announced.

ORGANIZED MEDICAL STAFF ESSENTIAL

The medical staff should be organized to carry on the professional medical work of the hospital, promote good team work and consultation, and, in general, take an active, constructive interest in the professional policy of the institution. They should hold staff conferences at regular intervals to discuss the work of the hospital and to see that there is a proper audit and check-up made in order to secure the best results. They should coöperate with the board of trustees in drafting staff rules and regulations to govern the professional work of the hospital and should record the minutes of their proceedings in a book kept for that purpose. They should be organized in such a way as to make coöperation with the board of trustees and with the administrative staff of the hospital easy and inevitable.

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SUPERINTENDENT OF THE SCHOOL FOR NURSES

The opening and developing of a school of nursing is the work of a competent superintendent, or director, of nursing, working in coöperation with the educational committee of the board. She should be a woman who has many of the qualifications enumerated for the superintendent. She must have all the personal and technical qualifications which will make her a leader in her work. Educational courses for nurses are today very well standardized through state and provincial regulations. Standards are set and the basis for starting a training school is not difficult to follow. The superintendent of the hospital must be held responsible for selecting the right type of woman for this work. Having secured her on definite terms, he should give her the responsibility of forming the hospital's first school of nursing, as well as formulating the organization necessary to give the patients a sound, practical nursing service. The superintendent of nurses must be held responsible for all matters pertaining to her department and should recognize her responsibility to the chief executive officer.

PROFESSIONAL AND LAY STAFFS

Many other professional staff members are required, such as the laboratory director, the radiologist, the pharmacist, the dietitian, the interne and the physio-

therapist. All these are more or less specialists in their departments and should be appointed by the board of trustees upon the recommendation of the superintendent and the chief of the medical staff, or a committee thereof.

Choosing the lay staff is a matter which should be done by the superintendent, if the hospital is small; by the heads of departments, if it is large. First, the number and type of employees required must be determined, and second, the salaries to be paid.

Having selected the entire administrative staff of the institution and having organized them along their respective lines of duty, it would be wise to call them together at the earliest opportunity and talk to them about their work and their responsibilities, urging loyalty and coöperation in the best interests of the hospital.

Once the hospital is built, equipped, organized and ready to receive patients, the institution should be dedicated to the community service for which it was designed.

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CHAPTER IV

FINANCING NEW HOSPITAL CONSTRUCTION

ONE of the most important, and often one of the most difficult, steps that must be taken in starting a hospital is to secure the funds with which to construct the building or buildings. An effort will be made to describe various ways of doing this. It is not our purpose to discuss the subject of how money may be realized for the construction of additions to already existing hospital plants, much less for current maintenance or to meet a deficit, although principles and methods that obtain in the former case may find more or less application in the latter.

WINNING COMMUNITY'S LEADERS TO PROJECT

It is important first of all to see that the leaders in the community are impregnated with the idea of hospital preparedness; that they see the wisdom of providing a hospital now so that it may be ready against the day of illness or accident. Their endorsement should be made the beginning of the educational propaganda, and upon their shoulders should be placed the task of selling the hospital to the people as a whole.

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Through their personal visits they carry information and conviction to uninformed and doubting minds.

THOROUGHLY INFORMING THE PUBLIC

Fundamental to almost any desirable method of raising funds is the thorough education of the public, or that part of the public from whom contributions are to be sought, as to the proposed institution, the community's need of it, how it will serve its citizens and the demands it will make for support. This educational process is essential to any lasting success, whether the contributors to the building fund be few or many, and it is especially essential in the construction of a community hospital.

THE DANGER OF FINANCIAL SUPPORT BY FEW

The hospital must be sold to the community as a whole and an effort should be made to make every individual feel he has a moral obligation to contribute to the building and later to the maintenance of the institution. To omit this is to run the risk of failure in getting any large percentage of the community to support the hospital, and of the hospital's finding itself in the regrettable position of being started by a small, and often more or less exclusive, group on whose gifts and individual credit the hospital is forced to rely for its existence. This is a serious mistake. The average citizen must be interested in supporting the

hospital, just as at present, by paying his taxes, he furnishes funds for the construction of schools and of fire and police stations and their equipment. Writing on this subject in *The Modern Hospital*, Mr. G. W. Olson, former superintendent of the Swedish Hospital of Minneapolis, Minn., said: "The direct appeal to the whole people of a community, preceded and accompanied by a broad democratic and deeply earnest selling campaign, appears to be the only method by which the money needed by our hospitals can be secured."

METHODS OF RAISING FUNDS

The modern facilities for educating the public are so well known that it is scarcely necessary to enumerate them here. Some of the special methods that are used in the intensive financial campaign will be described more in detail in the discussion of that subject.

Of taxation and the floating of bond issues as a method of providing funds for the construction of new hospitals by the state, or one of its political subdivisions, we shall have nothing to say. However men may differ on the theory of taxation and however difficult it may be to arrive at a just basis of taxation, the fact is that whenever a state, a county or a city embarks upon the construction of a new hospital, funds are provided for its erection by a vote of the money-raising body, either through an appropriation from the

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general tax fund, the levying of a special tax or the voting of a bond issue. Nor shall we say anything about the raising of funds by an individual or a small group of individuals for the construction of a private hospital organized, much as a hotel is organized, to render a community service on a profit-making basis.

RAISING FUNDS THROUGH BOND ISSUES

In some instances where the subscriptions, either in the form of contributions, membership or stock subscriptions, have not been sufficient to put through the completed building program, a bond issue has been floated. These bonds of course are interest-bearing. The retirement of the bonds and their interest is usually provided for from the earnings of the hospital. As this scheme throws the burden of building a hospital partly on the sick who choose to resort to it, it is frowned upon by some as unethical. It is evident, of course, that an issue of bonds, the interest of which is to be met from the earnings of the hospital, cannot be considered unless the hospital has a number of private rooms the income from which will meet the regularly recurring interest payments, as well as create a sinking fund for the retirement of the bonds at a stipulated time.

THE INTENSIVE FINANCIAL CAMPAIGN

Whether the purpose is to raise funds for a community chest, for a group of hospitals or for an indi-

vidual hospital, the intensive financial campaign has met with very general success and, if carried on under capable leadership, is one of the most effective instruments for raising large sums of money for building purposes.

For this purpose no more effective instrument has as yet been devised than the intensive financial campaign. This organized means for raising money was first used by Mr. Charles Summer Ward, in raising funds for new Y. M. C. A. buildings and was later used by various institutions, such as schools, colleges, hospitals and homes for children and the aged.

During the European War, when vast sums of money had to be raised rapidly, not only for private welfare agencies but for governmental activities, the so-called "drive" was brought into intensive use. And this experience, together with the modern tendency of business to coöperate in order to secure the largest results with the least amount of effort and expense, has established the intensive campaign as an efficient way of raising relatively large sums of money quickly. We have already emphasized the fact that no campaign should be entered upon until a competent, disinterested person or organization has first determined, by a local survey of the community's needs, that the proposed hospital is necessary. This will serve to assure the public in a very effective way of the soundness of the investment.

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METHOD OF ORGANIZING THE CAMPAIGN

The short term campaign is simple, rapid and economical. It accomplishes in a comparatively few days results that under other methods often take months and years. The usual procedure is to form an organization of the leading men and women of the community who give portions of their time for a few days to a thorough and systematic canvass. Prior to this canvass, the public is fully informed about the new project through the press, the pulpit, the mail and other channels. The general interest thus aroused makes the soliciting of funds fairly easy and agreeable. The work of preparing for the actual solicitation of funds usually takes from four to eight weeks.

This period of preparation, which is largely in the hands of the campaign director, is exceedingly important; the success of the campaign largely hinges upon it. During this period the list of names of persons to be interviewed is drawn up, committees and teams are organized, publicity is prepared and issued and various other details are perfected. Seldom does one find in a community any one individual who has had the experience and can give the time to organize the multiplicity of detail involved in a campaign of this type. The employment of an experienced campaign director, therefore, is almost inevitable. The period for the actual solicitation of the money usually runs from six to ten days.

CAMPAIGN SHOULD YIELD MORE THAN MONEY

A well-conducted campaign will yield more than money. Through the educational work, it will win many staunch friends for the hospital and build up a backing that cannot be calculated in terms of money. Many citizens will for the first time realize the importance to the community of a well-conducted hospital. Ill-founded impressions that the hospital is a place of last resort will be dissipated. What such a campaign meant to one county is well expressed in the following excerpt from an editorial in its local paper: "The campaign raised the dormant enthusiasm in community spirit in this county, which has been hitherto undeveloped, and in fact, it is our belief that the effort along this line is actually of more importance to the whole district than the \$300,000 which was raised for our hospital; . . . not only was this community left a hospital, but also a stimulus to encourage the people here to do big things, things which before seemed impossible."

SELECTION OF CAMPAIGN DIRECTOR

The selection of the campaign director is one of the most important steps in undertaking an intensive financial campaign. The campaign director should not be employed on the strength of hearsay evidence or of any printed matter he may issue as to his capabilities. A thorough, critical investigation should be made

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both of the man and of the organization, its methods and accomplishments in the current year. Whatever his qualifications, and they are many, he must be a man of unquestioned integrity as well as of wide experience. For the sponsors of a new hospital project to place the leadership of the campaign in the hands of a tyro, or of a person whose integrity is under suspicion, is to court failure. But with an experienced director or organization who, in the light of the results of a careful community survey, is willing to undertake the campaign, the hospital's chances of success are excellent.

EXPENSES GUARANTEED BY CAMPAIGN COMMITTEE

The hospital's campaign committee and not the campaign specialist should hold itself responsible for the campaign, the persons conducting it and any official statements or promises made during it. The campaign committee should guarantee all the expenses of the campaign and pay a fixed fee for its direction. Commissions should be frowned upon. The desire to increase their income may tempt campaign specialists to secure contributions by measures that react most unfavorably upon the hospital and its place and influence in the community. Employing a director on a commission basis, moreover, gives unwilling contributors an opportunity to assert that, if they contribute to the hospital during the campaign, a portion of their

gift will go into the pockets of the campaign specialist. Rather than have this happen they will refrain from giving altogether.

FINANCE COMMITTEE ESSENTIAL

A finance committee should keep an accurate record in detail of the money pledged and the funds received during the campaign. For obvious reasons this should not be the responsibility of the campaign director. At the end of the campaign the records should be audited by a certified public accountant, and the reports submitted either to the contributors or to the public at large.

INTENSIVE CAMPAIGN ECONOMICAL METHOD

This scheme is economical in its operation for, by the compression of countless solicitations extending over the entire year and a number of campaigns into one annual campaign, there is effected a saving of time and expense that is unanswerable. A campaign, for example, held early in 1921 for \$300,000 for the construction of a new hospital in one of our mid-western states, was conducted at a total cost of less than 3.5 per cent. Conditions, of course, vary somewhat in different communities and the cost of conducting a campaign may vary in consequence, but it will seldom run beyond 5 per cent or 6 per cent, and this, it will be observed, is merely the interest on the fund

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for one year. The campaign conducted in 1919 by the Cleveland Community fund, which brought in \$4,015,000, cost but 2.8 per cent and this was further reduced by the interest of funds on deposit, making the net cost of the campaign 1 per cent. The Community Chest of Rochester, New York, raised, in 1920, \$1,164,831 from 66,257 givers, at a cost of 2.7 per cent, and this cost was paid by one of the contributors.

COMMUNITY CHEST ASSIGNS TIME FOR CAMPAIGN

There has been some criticism of this method of raising funds, on the ground that thereby funds are raised for one hospital, quite regardless of the other hospitals in the community which are also filling a community need and require funds to further their work, a situation often giving rise to bitter enmity and rivalry. This criticism cannot very well arise in communities where the community's chest controls the situation and can assign to its various organizations a proper time for the conduct of their campaigns for capital funds, having first passed upon the need for such funds. For example, in the city of Rochester, New York, there was first the campaign for the Y. M. C. A. Then this was followed by campaigns for St. Mary's Hospital, the Knights of Columbus, and finally the United Hospitals, the last mentioned campaign showing that organizations with similar aims can sometimes be grouped together to advantage and that community chests may

well direct these groupings to prevent too many single campaigns in a year. At this writing (October, 1923) the Cleveland Community Chest has mapped out a plan under which a number of Cleveland welfare agencies will, during a period of five years, be given the right of way to go before the citizens of Cleveland for the sum of \$20,000,000.

INCLUSION OF CAPITAL FUNDS IN CHEST NOT DESIRABLE

It has been suggested that the activities of community chests be enlarged to include not merely the collection of maintenance funds but also capital funds for new construction. Experienced campaign directors, however, feel very strongly that the raising of capital funds should not be included in the community chest. It would clearly be impossible to put several in at one time. It is, however, highly desirable that the individual institutions have an opportunity occasionally to go before the public and present their needs uncomplicated by any association with other institutions.

SPECIALLY DESIGNATED GIFTS

Barring bequests and large gifts from the various educational and philanthropic organizations, the major part of the funds raised for the construction of new hospitals are invariably in the nature of out-and-out contributions. They may be, and invariably are, for the general building fund of the institution, but occa-

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sionally a contributor will wish to designate the specific object for which his gift is to be used, as, for example, the construction of one of the operating rooms, the nursery or the *x*-ray suite. During a financial campaign conducted in 1915 by the Brooklyn Hospital for capital funds for their new building, they issued an attractive booklet which carried some helpful suggestions for the finance committee of a new institution. This pamphlet, in addition to containing statistical figures about the hospital, an account of its present activities, neat floor plans and artistic sketches of prospective buildings, contained the following suggested gifts to the hospital, carefully calculated estimates of the cost of different parts of the institution. It goes without saying that, for the purpose of this discussion, these estimates are purely illustrative and must of necessity be different from time to time and in different localities.

SUGGESTED GIFTS FOR HOSPITAL

- \$25,000 will build the clinic lecture room.
- 20,000 will do all the work on the roads, walks, and grounds.
- 15,000 will pay for the garage complete.
- 15,000 will equip the laundry.
- 15,000 will build 1 of 2 operating rooms.
- 12,500 will build the superintendent's house.
- 10,000 will build the office department.
- 10,000 will build 1 of 2 delivery rooms.
- 10,000 will build 1 of 4 3-bed maternity wards.
- 10,000 will build the nursery.
- 10,000 will build 1 of 2 4-bed maternity wards.
- 10,000 will build 1 small operating room.
- 10,000 will build 1 private ward.
- 10,000 will build 1 of 2 internes' departments.
- 5,000 will equip the photographic room.

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SUGGESTED GIFTS FOR HOSPITAL—*Continued*

- \$5,000 will equip the x-ray room.
- 5,000 will build 1 of 2 recovery rooms.
- 5,000 will build 1 of 3 private rooms.
- 3,300 will buy 1 automobile ambulance.
- 2,500 will equip 1 of 2 operating rooms or pathological laboratory.
- 1,000 will equip 12-bed ward and duty rooms.
- 1,000 will equip small operating room.
- 500 will maintain charity bed for one year.
- 500 will equip examination room.
- 500 will equip ward laboratory.
- 500 will equip emergency surgical ward.
- 500 will equip ward diet kitchen.
- 500 will equip 1 of 2 emergency treatment rooms.
- 300 will maintain child bed for one year.
- 250 will equip 6-bed ward.
- 200 will equip 4-bed ward.
- 150 will equip private room.
- 100 will furnish 2-bed ward.
- 50 will furnish bed and equipment.

PAYING SUBSCRIPTIONS IN INSTALLMENTS

Many of the contributors will wish to pay their contributions at the time the contribution blank is signed. It is very desirable, however, to give contributors the opportunity of paying their contributions in equal quarterly or, in some instances, monthly installments, beginning at a time clearly specified on the subscription blank. It is seldom wise to let these payments extend over a period greater than two years. Rarely is a hospital completed before the last of the quarterly payments are due from contributors, but should this situation arise it is usually possible to borrow the funds needed to pay contractors from the local bank, giving as collateral the unpaid subscription blanks, which of course should be in negotiable form.

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RAISING CAPITAL FUNDS THROUGH MEMBERSHIP

Some hospitals have attempted, and in a measure succeeded, in raising capital funds by means of the membership plan. Memberships are definitely sought with a view to allying givers with the institution for an indefinite, though prolonged, period of time and, of course, in the case of life membership, for life. This plan for raising capital funds is far from desirable, since the lower standards set invariably hinder the securing of liberal gifts. Moreover, contributions quite as much as memberships may be used as the basis for the establishment of the hospital corporation or association.

NON-DIVIDEND BEARING CAPITAL STOCK

Another form that gifts to the building fund of the new hospital may take is subscriptions to the non-dividend bearing capital stock of a hospital association. These certificates of stock should preferably be of one denomination and small enough to permit of a very wide subscription. Shares in fifty-dollar denominations are none too small and if necessary provision may be made for their payment in five installments of ten dollars each over a specified period. The first payment should be made when subscribing for the stock or at any rate at some definite date agreed upon. One hospital which employed this scheme recently arranged to have five payments to the stock made as follows: First

payment when the stock was purchased: second payment when the basement of the hospital was built; third and fourth payments when the superstructure was being erected and the fifth payment when the building was completed. Calls were sent out for the various payments from time to time and checks were mailed to the two local banks which acted as depositories for the funds of the hospital association. In another instance the stock was either paid for in full at the time the subscription was filed or 10 per cent of the total subscription was paid when the subscription was signed and the balance in nine equal monthly payments of 10 per cent of the total subscription, the date of the second payment being specified and the remaining payments being made on the same day of each succeeding month until full payment had been made.

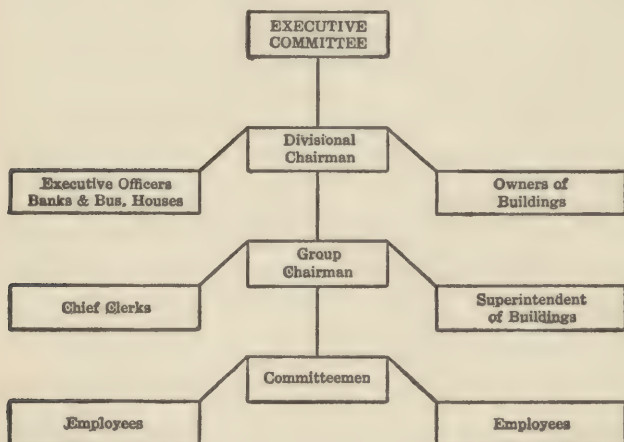
But while this form of gift may have its disadvantages in isolated instances, those who are experienced in the raising of capital funds for institutions, generally speaking, found no more advantage in the issuance of non-dividend bearing stocks than in the issuance of memberships; both, in their opinion, are equally undesirable in that they hinder rather than stimulate the securing of liberal gifts.

RECENT INTENSIVE FINANCIAL CAMPAIGNS

The vital importance of educating the public as to the work and needs of a hospital is admirably illus-

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trated by the financial campaign that was conducted in lower New York for the Broad Street Hospital. One million five hundred thousand persons had to be told of the hospital before the actual solicitation of funds was begun. The accompanying diagram will show how those who participated in the campaign were organ-



ized. The executives appointed the divisional chairmen, who in turn not only appointed the group chairmen but were responsible for informing the officials of large banks and business houses as to the objects of the Down Town Hospital Association, and getting them to serve as a sponsoring committee for the association. The group chairmen were detailed to rouse the interest of the chief clerks and other officials of the various commercial and banking houses and through them pass on literature to employees in general. It

was the task of committee chairmen to address groups of employees and to be responsible for the follow-up work.

The intensive publicity work was carried on by means of huge banners swung across the main streets carrying the legend: "Downtown Is Our Town, It Needs Your Help"; posters placed in the windows of banks and business houses; stickers on the menu cards of clubs and restaurants and tea rooms; slogan buttons, and, above all, the newspapers. The newspaper material was carefully edited and, in instances where newspaper reporters were invited to the hospital, prepared statements were furnished them to guard against misstatements and exaggerations.

Commenting on the campaign, Miss M. E. Montague, assistant superintendent of the hospital, said: "What has happened since has justified the decision that publicity is the important agent for the performance of the work, but no two hospitals should use the same appeal. The situation may seem to be exactly alike at the first glance, but a close examination will reveal a dozen points of difference, any one of which may mark the turning point between success and failure. Between the science of advertising and the art of selling an idea there is much the same difference as between studying surgery in the university and practicing it in an operating room. This was demonstrated in the use of a charting board for team contributions.

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The psychology of public competition is unquestionable, but the usual clock and thermometer system of recording the progress of the different teams has been used promiscuously in this district. Hence the use of a chart. This carried out the same idea presented in a new way. The chart was placed on the most conspicuous corner of the district, the corner of Wall and Broad Streets. Each team captain was represented as a volunteer ambulance driver with a command to 'Answer the Call' to the hospital with his quota. Each ambulance was numbered and the corresponding number with the name of division and driver was shown on each side of the chart. Each day the ambulance was removed by an amount corresponding to the subscription of the division for the day."

The short term campaign conducted at Champaign, Ill., in the summer and autumn of 1921 is an illuminating example of what can be accomplished in an uninterested community even in the face of apparently insuperable obstacles. St. Mary's, now Mercy Hospital, began its career in January, 1918 in a remodeled dwelling with a capacity of twelve beds. It was crowded to capacity from the very beginning and it soon became evident that the hospital must expand its facilities.

The indifferent success which several other hospitals had met in conducting financial campaigns led many to doubt the wisdom of conducting another one.

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Moreover, at the time the campaign was contemplated a number of other financial drives were scheduled, including those of the Boy Scouts of America, the Salvation Army, the American Red Cross, a \$225,000 bond issue of the Urbana Hotel Fund which was being floated among the citizens of the twin cities of Champaign and Urbana. The wisdom of attempting the erection of a new building at this time and the question of its location created discussion in the church itself.

But despite these obstacles, a thorough-going survey of the situation by a campaign expert indicated that the project had an excellent chance of being successful and it was therefore undertaken. Campaign headquarters were opened on August 15, 1921. A little over two months was given to preparation and, at the end of the two weeks actually devoted to pledge-taking, \$152,000 had been promised. A whirlwind canvass of the county by the women's division boosted the total to \$153,266.

How the result was attained is the story of scientific organization brought about by an experienced, competent campaign director. "At the start," writes the Rev. Father Richard F. Flynn, "twelve public-spirited men of Champaign met and, after canvassing the ground thoroughly and carefully considering the detailed report of the survey, agreed to underwrite the expenses of the campaign. The campaign once begun, a second meeting of this group of twelve was called, at which

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time each was asked to bring in five others to form the men's campaign committee. Seventy-five men were present at this next session and later the campaign committee was enlarged until it numbered some 200 men. In addition to this an executive committee of ten was formed. This was composed of the chairman from Urbana, the county chairman, and his two vice-chairmen and a chairman of organization. The advisory committee was made up of the general chairman, the campaign treasurer, a prominent Catholic layman, a well-known Protestant layman and myself."

A women's division was also organized. This included several hundred of the especially prominent women of the university community and the Twin Cities.

The campaign had the endorsement of the Chamber of Commerce, of both the Rotary and the Kiwanis Clubs, the Elks, the Knights of Columbus and other civic organizations.

One of the unique features of this campaign was that the medical profession was not asked to participate except as individuals, due to the fact that nearly all of the local physicians were affiliated with another hospital in the city. "This delicacy and appreciation," says Father Flynn, "of the ethical standards of the profession made a profound impression on the local medical fraternity. They have now, however, an important part since the actual building is under way. A strong medical staff is now one of our greatest assets."

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The newspapers of the Twin Cities and the county gave the campaign liberal publicity, thereby enabling the hospital to tell its story without a heavy expenditure for advertising. Billboards, lithographs, feature contrivances and other expedients to rouse interest were not used.

Early in 1923, the city of Rochester, New York, furnished a stimulating example of what can be done to raise capital funds in a united hospital fund campaign. Prompted by the success of St. Mary's Hospital, Rochester, in raising \$354,000 through a well-organized campaign in which the objective was but \$225,000, the Rochester General Hospital decided to conduct a financial campaign for the purpose of raising several hundred thousand dollars. But, when they placed their plan before the directors of the Rochester Community Chest, the latter decided that not the General Hospital alone but also the Highland Hospital and the Homeopathic Hospital should join in a united capital account appeal for \$1,300,000. Throughout this campaign great pains were taken through well-organized publicity to familiarize the public with the activities of these institutions. Especial emphasis was given to the fact that the hospitals' annual operating deficits were cared for through gifts to the community chest and that the chest did not provide for building funds or for the hospitals' present debts, other than accrued interest on them.

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Before beginning the campaign, it was agreed that the employees of the various establishments in Rochester should not be solicited in groups. This is done each year in behalf of the community chest which provides for hospital maintenance deficits. This campaign for capital funds was, therefore, undertaken with the understanding that subscriptions should be solicited from citizens of large giving ability or from among those on personal and individual solicitation lists.

At the outset of the campaign members of the various boards of trustees of the hospitals interested, members of their medical staffs and the hospitals' executives were asked to attend a complimentary dinner given at the Genesee Club by one of Rochester's citizens anxious to see the fund raised. Two hundred and thirty-six men and women were present. The purpose of the dinner was twofold: first, to ascertain if every one thoroughly understood the hospitals' needs and the steps that had thus far been taken by the campaign committee; second, to inform those in attendance that they, as responsible representatives of the hospitals affected, could not expect others to do anything for them unless they were first ready to do something for themselves. They were told very frankly that they could interest and enlist others if they themselves were willing to work. This was willingly agreed to, every person in the room asserting that he or she would not refuse to do anything asked in behalf of the campaign.

The history of the campaign shows that not a single request was refused.

At this meeting a capable chairman was elected and other essential leadership enlisted. An "advance gifts" committee planned its activities but did little work until about five or six weeks before the intensive period of the campaign. In the meantime 392 of the leading people of Rochester were enlisted on forty-nine working teams.

Rochester's success in this campaign, it is asserted, was due to the fact that the movement was put on the shoulders of the people who controlled the giving. One of the division chairmen recommended that his firm give \$100,000. A number of other division chairmen subscribed \$50,000 each, and even team captains signed up for \$25,000, \$10,000 and lesser amounts according to their financial resources.

The campaign did not make any unusual demands on the time of the solicitors. A quickly served luncheon report meeting was held daily in the hall of the chamber of commerce. Seven such report meetings were planned but only five were held, the goal having been passed on the fifth report.

Like many other skillfully conducted financial campaigns, the greatest accomplishment was not the amount of money raised, but the new understanding the people at large had of their obligation to create hospital facilities for themselves for their hour of ill-

ness or accident. "Rochester's hospitals," as Mr. Bert Wells puts it, "are assured that they are better off for having raised their capital funds independent of the community chest. Hospital needs, hospital service and the responsibility of the individual to be a part of his hospital, were emphasized. The men and women who took advantage of hospitals created through the charity of others, and then came away with an attitude of mind that bred criticism and complaint, were shown the error of their way. A broader understanding of the fact that hospitals have made possible through their clinics the advancement of medicine and surgery of the present day; that the family physician owes his saving skill and ability to the present scheme of hospital practice; that the general good health of the world is traceable to research having its beginning in hospital practice; that public hygiene has its beginning in hospital development—all of these things were definitely established and were endorsed by the gifts of Rochesterians to a total greatly exceeding the hospitals' immediate needs."

This campaign cost \$28,015.05, or a little over 2 per cent of the amount raised.

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CHAPTER V

ORGANIZATION OF PERMANENT AUXILIARY BODIES

THERE can be no question of the desirability of having a large group of women actively interest in, and working for, the community hospital through a well-organized auxiliary body properly integrated with the management of the institution. In every community there are many women who, while carrying other responsibilities, are nevertheless willing and even anxious to have a part in the community's hospital.

It is not within our province to enter into a long discussion of the countless ways in which the women of any community, properly organized, can assist its hospital. Opportunities vary with the circumstances and purpose of each institution. Suffice it to say that no auxiliary board once organized need find itself at a loss for things to do. There are funds to be raised, linen to be made up and mended, visitors to be supervised, to mention only a few of many possible activities. A hospital may be efficiently planned and substantially built, it may be thoroughly equipped with the most modern devices, its personnel may be well or-

ganized, yet, if it lacks an auxiliary board, it is losing a rare opportunity to enrich its service, to say nothing of the good will it can thereby build up in the community.

TYPE OF AUXILIARY BOARD

Assuming that a hospital is fully persuaded that a women's auxiliary board is a desirable body to have connected with it, the question immediately arises as to what type of board should be organized. Should it be a single board comprising a large number of women organized for the sole purpose of helping the hospital in any way that the hospital's board of trustees may think desirable? Or should it be a smaller board whose purpose it is to supervise a number of separate guilds or societies, each of which is organized solely and specifically to assist the hospital in ways that shall have the approval of its board of trustees? Or, finally, should it be a board organized to coördinate the hospital activities of a number of guilds, clubs, and societies having varied interests and activities? Each has its advantages and the choice of any given hospital will undoubtedly be influenced somewhat by the conditions that prevail locally.

SINGLE BOARD ORGANIZED TO SERVE ONE HOSPITAL EXCLUSIVELY

Many hospitals now have the first type of auxiliary board and much can be said in its favor. A board pur-

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posely formed to direct all of its activities in the interest of a given hospital will unquestionably give the hospital concentrated and continuous service and, in an emergency, its resources can be quickly placed at the command of the institution. It tends, however, to duplication of organization and membership, and some communities are already so highly organized that an additional society is highly undesirable.

SMALL BOARD SUPERVISING HOSPITAL GUILDS

In a few communities we find the second type of organization. While this type differs somewhat in its method of operation, in its practical results it differs little from the first type.

SMALL COÖRDINATING BOARD

An increasing number of hospitals are adopting the third type of organization, *i. e.*, the organization of a small board the function of which is the coördination of the hospital activities of a number of guilds, clubs and societies, which, though varied in their composition and interests, nevertheless have a broad latent capacity for service and many willing hands to work. This type of auxiliary organization has a number of advantages. It serves as a valuable connecting link between the hospital and the citizens of the community at large. Through well-organized contact and a wider personal interest, it offers a splendid agency for making the hos-

pital better known in the community and promoting a spirit of good will and coöperation. It has a favorable influence in stimulating coöperation and greater efficiency in the hospital itself. It provides a channel through which many needs of the institution, which, though properly regarded by its board of trustees as beyond the institution's means, can be met in a more comprehensive way than could be done if either of the other two types of organization prevailed, since it introduces a broader range of interests in the community.

This type of organization, however, has some disadvantages. There is a divided interest among the different constituent societies which may at times react unfavorably toward the hospital. Moreover, the assistance each society gives the hospital is often determined not by the institution's needs but by the demands being made upon the society in other directions.

It would seem, however, that on the whole the advantages of this scheme of organizing the hospital's auxiliary service outweigh the disadvantages.

LEADER WITH INITIATIVE ESSENTIAL

In facing the organization of an auxiliary board, whatever its type, the hospital must find some person who will take the initiative and carry the project to a successful conclusion. Possibly a member of the board of trustees, especially a capable woman member, may be sufficiently inspired with the idea to undertake the

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leadership necessary to get the auxiliary board started. On the other hand, it may be thought wise to place the inauguration of the auxiliary board in the hands of a small committee of the board of trustees. As the auxiliary body must be subject in all matters to the board of trustees, it is clearly incumbent upon the board to initiate the movement for the organization of this group.

TRUSTEES FORMULATE AUXILIARY'S PLAN OF ORGANIZATION

It is the duty of the board of trustees to formulate a definite plan for the organization of the hospital's auxiliary board. This may be embodied in a preliminary report to be submitted at a meeting called for the organization of the new body. The report should be interesting, convincing and as complete as possible, presenting a practical, though not necessarily final, scheme of organization. It should aim to emphasize the worthwhileness of the proposed work and arouse an interest in it. It should tell of the progress that has thus far been made, point out the value of the hospital to the community in terms of service in caring for and treating patients, in training doctors and nurses, in research, and in maintaining the health of the community, outline the services which the hospital, with additional support, can render the community, urge the need of voluntary effort to supplement the work of the

paid staff, and give an outline of what these activities should include.

After the meeting has been fully informed of the project and ample time has been given for questions and discussions, a motion calling for the inauguration of the auxiliary board will be made.

ADOPTION OF CONSTITUTION AND BY-LAWS

The next step will be the presentation and adoption of the constitution and by-laws which have been previously, but provisionally, formulated by a committee of the board of trustees. This constitution should be given careful preliminary consideration and should not include anything likely to arouse prolonged controversy. The document should at least embody the following data: (1) The name of the organization; (2) purpose or purposes; (3) membership; (4) officers; (5) duties; (6) meetings; (7) relations, especially to the governing board and the superintendent of the hospital.

BASIS OF MEMBERSHIP

If the auxiliary board is of the first type, namely, an association of women for the sole purpose of assisting the hospital, the membership will be on a basis of individuals, each individual paying a fixed membership fee. If the board is of the second or third type, its membership will properly be made up of representa-

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tives of the different affiliated organizations, augmented, if thought desirable, by additional individuals appointed directly by the board of trustees of the hospital.

COMMITTEES TO BE APPOINTED

As soon as the board is organized, it will be well to elect officers and have the president appoint the necessary committee, including an executive committee consisting of the officers and, if deemed desirable, three additional members.

The duties of the officers will be those customary in any similar organization and need not be enumerated here. But let it be emphasized that great care needs to be exercised in selecting the right kind of persons to fill these positions.

SCOPE OF AUXILIARY'S ACTIVITIES

The auxiliary board will undertake whatever activities may wisely be carried on by such a board with the approval of the hospital's board of trustees. Some auxiliaries undertake to do certain specific things, as, for example, provide the hospital with all its linen. While this is undoubtedly a desirable plan, it would be well if the board might be regarded as a body that could be called upon to meet any one of a number of needs as they arise from time to time. This, of course, involves flexibility and a ready adaptation to the assigned task.

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MEETINGS OF THE AUXILIARY

The auxiliary board should have an annual meeting at a stated date indicated in the by-laws. At this meeting the president or secretary should present a brief review of the work of the past year and the treasurer should submit a financial report. At this time, moreover, the officers for the coming year should be elected and various committees appointed. Regular meetings of the board should be held every month, every three months, or at other stated periods. Provision should be made in the constitution for calling special meetings on the signed request of a specific number of members.

The executive committee should meet frequently and at least once a month. A well-arranged agenda should guide the deliberations. The agenda may be something like this: roll call; reading of the minutes of the previous meeting; unfinished business; reports of standing and special committees; communications; new business; adjournment. Notice of all meetings should be sent out by the secretary at least a week before the date of the meeting. It would be well to have a regular time and place for meetings.

MANAGEMENT OF HOSPITAL NOT ONE OF AUXILIARY'S DUTIES

In conducting the affairs of the auxiliary board, it must always be borne in mind that the purpose of the board, broadly speaking, is to assist in the work of the

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hospital and not in any way to manage its affairs. The latter activity is the function of the superintendent, with whom, of course, the auxiliary board should keep in constant touch. Indeed, the auxiliary board may well look to the superintendent of the hospital, acting as the representative of the board of trustees, for specific guidance and suggestions as to the activities in which it should engage. This does not mean, of course, that the board itself and its members should not offer suggestions regarding the work in which it should engage, but it does mean that these suggestions should not be translated into action until they have the full approval of the hospital's board of trustees acting through its representative, the superintendent. Once the auxiliary board arrogates to itself any of the executive functions of the superintendent, there is bound to be needless trouble and friction, and unless this is checked immediately irreparable harm may be done. Where the auxiliary board, however, works hand in hand with the superintendent and consults him frequently with regard to its work, it can be an instrument of incalculable service to the hospital.

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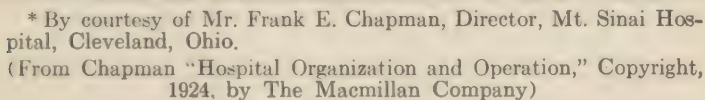
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APPENDICES

APPENDIX

1. Chart of General Organization.
2. Example of the Law Providing for the Formation of Corporations not for Pecuniary Profit.
3. Blank Form of Certificate of Incorporation.
4. Example of Hospital Charter.
5. Examples of Articles of Association or Incorporation.
6. Examples of Hospital By-Laws.
7. Statement of American Institute of Architects Relating to the Functions of the Architect.
8. Standard Form of Agreement Between Owner and Architect.
9. Standard Form of Agreement Between Contractor and Owner.
10. Standard Form of Bond.
11. Suggested Form of Subscription Blank.
12. Lists of employees of hospitals having a capacity of 35, 50, 100 and 169 beds, and their compensation.
13. Annual earnings and expenditures of hospitals having a capacity of 35, 50 and 100 beds.

CHART OF GENERAL ORGANIZATION*



APPENDIX 2

THE LAW OF THE STATE OF ILLINOIS PROVIDING FOR THE FORMATION OF CORPORATIONS NOT FOR PECUNIARY PROFIT ¹

Section 29. Societies, corporations and associations (not for pecuniary profit) may be formed as hereinafter provided. Any three or more persons, citizens of the United States, who shall desire to associate themselves for any lawful purpose, other than for pecuniary profit, may make, sign and acknowledge, before any officer authorized to take acknowledgments of deeds in this State and file in the office of the Secretary of State a certificate in writing, in which shall be stated the name or title, which name or title shall be in the English language, by which such corporation, society or association shall be known by law, the location of the business office of the corporation by street and number, the particular business and object for which it is formed, the number of its trustees, directors and managers, which shall not be less than three, and the names and addresses of the trustees, directors or managers selected for the first year of its existence.

§ 30. Upon filing a certificate as aforesaid, the Secretary of State shall thereupon issue a certificate of the organization of the corporation, society or association, making a part thereof a copy of all papers filed in his office in and about the organization thereof, and duly authenticated under his

¹The provisions of the laws of the State of Illinois pertain to the formation of corporations not for pecuniary profit. These provisions differ in different states, and persons interested in the organization of a new hospital will do well to ask their secretary of state to send them copies of the state laws bearing on this question.

hand and Seal of State; and the same shall be recorded in a book for that purpose, in the office of the recorder of deeds of the county in which the principal place of business of such corporation, society or association is located. Upon complying with the foregoing conditions, the corporation, society or association shall be deemed fully organized, and may proceed to business: *Provided*, the Secretary of State shall not issue a certificate of organization to any corporation, society or association, under the name of any then existing.

§ 31. Corporations, associations and societies, not for pecuniary profit, formed under this Act, shall be bodies corporate and politic, by the name stated in such certificate; and by that name they and their successors shall and may have succession, and shall be persons in law capable of suing and being sued; may have power to make and enforce contracts in relation to the legitimate business of their corporation, society or association; may have and use a common seal, and may change or alter the same at pleasure; and they and their successors, by their corporate name, shall in law be capable of taking, purchasing, holding and disposing of real and personal estate for the purposes of their organization; may, by their trustees, directors or managers, make by-laws not inconsistent with the constitution and laws of this State, or the United States, which by-laws, among other things shall prescribe the duties of all officers of the corporation, society or association, and the qualification of members of the corporation, and shall provide for regular meetings of such members at least once in five years and for the calling of special meetings, when necessary, and for the number of members that shall constitute a quorum for the transaction of business at any such regular or special meetings. At any such meeting members of the corporation may take part and vote in person or by proxy. The by-laws of the corporation made by the trustees, directors or managers,

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may be modified, altered or amended at any such regular meeting, or at any adjourned session thereof, or at any special meeting called for that purpose. Associations and societies which are intended to benefit the widows, orphans, heirs and devisees of deceased members thereof, and members who have received a permanent disability, and where no annual dues or premiums are required, and where the members shall receive no money as profit or otherwise, except for permanent disability, shall not be deemed insurance companies.

§ 32. Corporations, associations and societies, not for pecuniary profit, formed under the provisions of this Act, may elect trustees, directors or managers from the members thereof, in such manner, at such time and places, and for such periods as may be provided by the certificate of incorporation, or in cases such certificate does not contain such provision, then as may be provided by the by-laws, which trustees, directors or managers shall have the control and management of the affairs and funds of the corporation, society or association. Said trustees, managers or directors may, upon consent of the corporation, society or association, expressed by the vote of a majority of the members thereof, present at any regular meeting or special meeting called for that purpose, provided, always, that a quorum be present, borrow money to be used solely for the purpose of their organization and may pledge their property therefor. Whenever trustees, managers or directors shall be elected, a certificate under the seal of the corporation, giving the names of those elected, and the term of their office, shall be recorded in the office of the recorder of deeds where the certificate of organization is recorded. Vacancies in the board of trustees, directors or managers shall be filled in the manner provided by their by-laws, and upon filling any vacancy a like certificate shall be recorded.

§ 33. No dividends or distribution of the property of such corporation, society or association shall be made until all debts are fully paid and then only upon its final dissolution and surrender of organization and name; nor shall any distribution be made except by a vote of a majority of the members. Whenever a majority of the members of such corporation, society or association shall wish to dissolve the corporation and abandon the corporate enterprise, the trustees, directors or managers shall call a meeting of the members in accordance with the by-laws, to vote upon the proposition of dissolving the corporation. Upon the passing of a resolution of dissolution in accordance with the by-laws of the corporation, the secretary of the corporation shall certify to the fact of the passing of the resolution of dissolution and the further fact that all the debts of the corporation have been paid and the property distributed among the members according to their respective rights, which certificate shall be under the seal of the corporation and verified by oath of the president and recorded in the office of the county recorder of the county wherein the business office of the corporation is located and filed in the office of the Secretary of State. Upon the filing of the certificate of dissolution duly recorded, the Secretary of State shall examine the same and if it is in conformity with the law, shall issue a certificate of dissolution. Upon the issuance of said certificate of dissolution by the Secretary of State, such corporation, society or association shall cease to exist. In case any statement made by the president and secretary of the corporation relating to the dissolution of said corporation shall be wilfully false, said officers shall be jointly and severally liable for the debts of such corporation, society or association.

§ 34. Any such corporation, society or association may change its articles of association, in the manner prescribed

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by their own rules; but no such change shall be of legal effect until a certificate thereof, verified by oath of the president, under seal of such corporation, society or association, shall be filed in the office of the Secretary of State, and recorded in the office of the recorder of deeds in which the original certificate was recorded.

FEES NOT FOR PECUNIARY PROFIT

That all societies, corporations and associations not for pecuniary profit, hereafter organized under the laws of the State of Illinois, shall pay to the Secretary of State before there shall issue a certificate of incorporation, a fee of \$10.00.

Section 10d of Chapter 53 of Hurd's Revised Statutes of Illinois.

APPENDIX 3

BLANK FORM OF CERTIFICATE OF INCORPORATION

The

.....

.....

Location

CERTIFICATE.

NOTE.—The Constitution provides that all Fees shall “be paid in advance into the State Treasury.”

FEE \$10.00.

That all societies, corporations and associations not for pecuniary profit, hereafter organized under the laws of the State of Illinois, shall pay to the Secretary of State before there shall issue a certificate of incorporation, a fee of \$10.00.

—Sec. 10d, p. 1325, Hurd’s Revised
Statutes of Illinois.

CERTIFICATE OF INCORPORATION.

(Continued on page 132)

THIS STATEMENT MUST BE FILED IN DUPLICATE.

STATE OF ILLINOIS, } ss.
 County, }

FEE \$10

To LOUIS L. EMMERSON, Secretary of State:

We, the undersigned
.....
.....

citizens of the United States, propose to form a corporation under an Act of the General Assembly of the State of Illinois, entitled, "An Act concerning Corporations," approved April 18, 1872, and all acts amendatory thereof; and for the purpose of such organization we hereby state as follows, to-wit:

1. The name of such corporation is
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2. The object for which it is formed is
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(Continued from page 133)

STATE OF ILLINOIS, }
 County, } ss.

I, a Notary Public in and for the
County and State aforesaid, do hereby certify that on this day of
..... A. D. 19...., personally appeared before me
.....
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.....
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.....

to me personally known to be the same persons who executed the foregoing certificate, and severally acknowledged that they had executed the same for the purposes therein set forth.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year above written.

(SEAL HERE)
Notary Public.

APPENDIX 4
EXAMPLE OF HOSPITAL CHARTER

Certificate Number _____



To all to whom these presents shall come, Greeting:

Whereas, a CERTIFICATE, duly signed and acknowledged has been
filed in the Office of the Secretary of State, on the _____ day of _____
A.D. 19____ for the organization of the _____

_____ and in accordance with the provisions of "AN ACT CONCERNING CORPORATIONS"
approved April 8, 1872 and in force July 1, 1872, and all acts amendatory
thereof, a copy of which certificate is hereto attached

Now Therefore, I, LOUIS L. EMMERSON, Secretary of State of the State of Illinois,
by virtue of the powers and duties vested in me by law, do hereby certify
that the said _____

_____ is a legally organized corporation under the laws of this State.

In Testimony Whereof, I have set my hand and cause to
be affixed the Great Seal of the State of Illinois.

I am at the City of Springfield this _____
day of _____ A.D. 19____ and
of the Independence of the United States
the one hundred and _____

SECRETARY OF STATE

APPENDIX 5

EXAMPLES OF ARTICLES OF ASSOCIATION

ARTICLES OF ASSOCIATION OF BUTTERWORTH HOSPITAL, GRAND RAPIDS, MICHIGAN

We, the undersigned, constituting a majority of the Trustees of Butterworth Hospital, and desiring to continue the Corporation known as Butterworth Hospital (the term of existence of which has expired by limitation), organized and existing under and by virtue of an act of the Legislature of the State of Michigan, entitled "An Act for the Incorporation of Charitable Societies," approved February 6, 1855, and the acts amendatory thereof, for the purpose of reorganizing said Corporation, do make, execute and acknowledge the following articles of Corporation and agreement under and by virtue of an act of the Legislature of the State of Michigan, entitled, "An Act to Provide for the Reorganization of Corporations or Associations for Religious, Charitable, Benevolent or Educational Purposes, the Corporate term of existence of which has heretofore expired, or may hereafter expire by limitation, and to fix the duties and liabilities of such renewed Corporations or Associations," being Act 110 of the Laws of 1889, approved May 23rd, 1889, and the acts amendatory thereof.

I

The names of the persons associating in the first instance, being a majority of the Trustees of said Butterworth Hospital, and their respective residences, are as follows:

Edward Lowe	Grand Rapids, Mich.		
Claude Hamilton	"	"	"
Harvey J. Hollister	"	"	"
George T. Kendal	"	"	"
Howard A. Thornton	"	"	"
Henry Idema	"	"	"
J. Boyd Pantlind	"	"	"
G. K. Johnson	"	"	"

II

The name of the Corporation shall be Butterworth Hospital.

III

The office of the corporation for the transaction of its business shall be located in the City of Grand Rapids, Michigan.

IV

The period for which it is incorporated is thirty years from the 3rd day of June, 1906.

V

The objects for which the said corporation is organized are to furnish a home and hospital for the sick and needy, irrespective of sect or creed, relieve the necessities of persons requiring any assistance by any charitable means that may seem proper, and to educate and train nurses for the care of the sick.

VI

The trustees shall be thirty in number instead of eleven, as heretofore. At the first annual meeting after January 15, 1923, such number of trustees shall be elected as will, together with those trustees whose terms are unexpired, increase the number of trustees to that herein provided. At

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said election the terms of office of the respective trustees elected shall be so fixed that approximately one-fourth of all the trustees shall serve for one year, one-fourth for two years, one-fourth for three years and one-fourth for four years. At each succeeding annual meeting trustees shall be elected to succeed those whose terms shall have expired, and each trustee so elected shall hold office for the term of four years from the date of his or her election and until his or her successor shall have been elected. Vacancies in the board of trustees from whatsoever cause may be filled by the remaining trustees until the next annual meeting, when such vacancies shall be filled by the election of a trustee for the unexpired term.

VII

The annual meeting of the corporation shall be held at 8:00 P. M. on the third Tuesday in January at the Hospital belonging to the corporation or at such other hour or place in the city of Grand Rapids, Michigan, as shall be designated by the trustees.

VIII

Any person elected by the trustees to membership who shall pay the membership fee herein provided for shall become a member of the corporation from and after the first day of July then next succeeding, provided, however, that the trustees may in their sole discretion admit any person to membership at any time during the year. The membership fee shall be five (\$5.00) dollars per annum, payable in advance on or before the first day of July in each year, provided, however, that the trustees may in their sole discretion remit all or part of the said membership fee in the case of members who are also members in good standing of any auxiliary board, guild or other organization affiliated with

Butterworth Hospital. Failure to pay such membership fee when due and payable shall operate to suspend the membership of the person in default and failure to pay the same by the first day of September after due notice of arrears given in such manner as the trustees may prescribe shall automatically terminate such membership.

IX

The regular officers of the corporation shall be five in number, namely, a president, a first vice-president, a second vice-president, a secretary and a treasurer, all elected annually by the trustees from their number. The by-laws may provide for other subordinate officers who shall be elected annually by the trustees from the membership of the corporation.

X

The powers of the Trustees may be delegated by the Trustees to such committee or committees as the By-laws from time to time adopted by such Trustees, may prescribe, and the Trustees may provide in such By-laws how such delegated powers may be executed.

XI

Any reputable physician, or surgeon, authorized by the laws of this State to practice medicine or surgery, shall be permitted to send his patients to and treat them at the Hospital belonging to this Corporation, subject to the consent and control of the Board of Trustees and under the general rules and regulations thereof, and of the Hospital.

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ARTICLES OF INCORPORATION OF THE GREATER COMMUNITY HOSPITAL ASSOCIATION, CRESTON, IOWA

We, whose names are hereto subscribed, have associated ourselves together for the purpose of forming a corporation, not for pecuniary profit under the provisions of Chapter Two (2), Title Nine (9), of the Code of Iowa and the various amendments thereto and we hereby adopt the following:

ARTICLES OF INCORPORATION

ARTICLE I

Said Corporation shall be known by the name, THE GREATER COMMUNITY HOSPITAL ASSOCIATION, and its principal place of business shall be located at Creston, Union County, Iowa.

ARTICLE II

The objects and business of said corporation shall be to own, establish, maintain, control and operate a general Hospital and Nurses Training School in connection therewith at Creston, Iowa, and to promote interest and activity through auxiliary associations and societies or otherwise throughout the neighboring communities in measures tending to conserve the public health and prevent disease and disability and to that end said corporation may take by gift, purchase, devise or bequest real and personal property and exercise any and all rights and powers conferred by law upon such corporations and do any and all acts incident to the exercise of such powers which may be necessary and proper for the promotion of its business and the accomplishment of its object and purposes.

ARTICLE III

Said Corporation shall endure for the period of fifty (50) years from the date of the filing of these articles for record unless sooner dissolved as provided by law; and these articles may be renewed from time to time as provided by statute in such case.

ARTICLE IV

Said Corporation shall have no capital stock nor issue any stock shares in any manner or form whatever or declare or distribute any dividends, profits or other valuable thing to any of the members or officers of the Association.

ARTICLE V

Said Corporation contemplates taking over the property and business of the Cottage Hospital Association of Creston, Iowa. Every person who has heretofore contributed the sum of Twenty-five Dollars (\$25.00) or more to the Cottage Hospital Association or who shall hereafter contribute the sum of Twenty-five Dollars (\$25.00) or more to the Association formed by these articles, shall be and become a member of this Association and each of said members shall be entitled to cast one vote and no more in any of the meetings of the Association. Churches, Lodges and other organized or incorporated societies may become members of said Association with like privileges, and on like terms as natural persons.

ARTICLE VI

The private property of the members of the Association shall be exempt from the payment of the debts of the Corporation.

ARTICLE VII

The business of said Corporation shall be conducted by a Board of Nine Regents which Board shall be elected by the

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members of the Association as follows: One-third of the members of said Board shall be elected at the first; one-third at the second; and one-third at the third annual meeting of the members, and the members of said Board shall serve for the term of three years. The Board of Regents may be increased to not exceeding fifteen members at any annual meeting of the members of the Association.

ARTICLE VIII

The regular annual meeting of the members shall be held at the office of the Association on the first Monday in October of each year after the year 1918, and twenty-five members shall constitute a quorum for the transaction of business.

ARTICLE IX

The Board of Regents shall hold their regular annual meeting at the same time and place as the members, and they may hold such special meetings from time to time as they may find necessary for the proper management of the business and affairs of the Corporation.

ARTICLE X

The Board of Regents who shall act until their successors are elected and qualified are here named by the Incorporators and are as follows: W. W. Morrow, J. D. Spaulding, Thos. L. Maxwell, Chas. T. Launder, A. B. Turner, Frank E. Sheldon, W. B. Murray, F. E. Sampson, Geo. D. Musmaker, one-third of whom shall act for one year; one-third for two years, and one-third for three years; to be determined by lot. Five members of the Board of Regents shall constitute a quorum for the transaction of business. Vacancies arising in the Board may be filled by the members at a special meeting called for that purpose, and vacancies in any other office may be filled by the Board of Regents at any special or regular meeting.

ARTICLE XI

The Board of Regents shall annually elect either from their own members or from the members of the Association, generally a President, a Vice President, a Secretary, and a Treasurer, all of whom shall perform the usual duties pertaining to the respective offices and be elected for the term of one year.

ARTICLE XII

The Board of Regents shall adopt such By-Laws, Rules, and Regulations as may be necessary to carry on the business and accomplish the objects and purposes of the Association, and employ such persons and help as may be required in the proper conduct of the affairs and business of the Corporation. And they may appoint such standing and special committees to aid them in conducting the business of the Association as may be found necessary.

ARTICLE XIII

Said Corporation shall never at any time incur an indebtedness greater in amount than to the extent of twenty-five per cent of the fair value of its tangible property.

ARTICLE XIV

Said Corporation shall adopt a seal of some appropriate design, and all conveyances of real estate and other documents authorized by the Board of Regents shall be executed by the President and Secretary under the seal of the Association.

ARTICLE XV

These Articles of Incorporation may be changed or amended from time to time as provided by statute in such case.

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ARTICLE XVI

The Hospital service of said Association shall never be denied to any person because of their financial inability to pay for such service at the usual rates and the Board of Regents shall adopt suitable Rules and Regulations for extending the benefits of such service and care to the poor and destitute.

APPENDIX 6

EXAMPLES OF HOSPITAL BY-LAWS

BY-LAWS OF BUTTERWORTH HOSPITAL¹

GRAND RAPIDS, MICHIGAN

ARTICLE I

Officers

Section 1. The regular officers of the corporation shall be five in number, namely: a president, a first vice-president, a second vice-president, a secretary and a treasurer, all elected annually by the trustees from their number. The by-laws may provide for other subordinate officers who shall be elected annually by the trustees from the membership of the corporation.

Sec. 2. The trustees may appoint one or more assistants to the secretary and to the treasurer, and prescribe their duties. They may also appoint an auditor with such powers of supervision over the operating finances of the corporation as they may delegate.

Sec. 3. The president shall preside at all meetings of the trustees and of the members of the corporation; he shall act as chairman of the executive committee; and shall in general exercise the powers common to the office of president.

Sec. 4. The first vice-president or, in his absence, the

¹This is an excellent example of the by-laws of a hospital. They were formulated after a painstaking study of the by-laws of sixty hospitals, by a special committee of Butterworth Hospital whose object was to formulate a group of by-laws that would serve as a standard and be thoroughly practical in the operation of a hospital.

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second vice-president shall exercise the powers and perform the duties of the president whenever the latter is unable to act.

Sec. 5. The secretary shall keep the records of all meetings of the trustees, the executive committee and the members of the corporation; he shall keep a record of the membership of the corporation; he shall attend to the giving of notice of meetings of the trustees, of the executive committee and of the corporation, whenever requisite; and he shall perform such other duties as may be assigned to him by the trustees.

Sec. 6. The treasurer, subject to the control and direction of the trustees, shall be entrusted with the custody and disbursement of all moneys belonging to the corporation; and, jointly with such other officer of the corporation as the trustees shall designate, shall have the custody of all securities belonging to the corporation and shall deposit the same for safekeeping in such place or with such bank or trust company, and upon such terms with respect to access and withdrawal as the trustees may from time to time prescribe. He shall render annually to the trustees, and oftener if required, a detailed statement of the financial transactions and condition of the hospital.

ARTICLE II

Trustees

Section 1. The general control of the property and affairs of the corporation shall be vested in a board of thirty (30) trustees consisting of twenty-eight (28) persons elected as hereinafter provided, and the Superintendent of the Hospital and the Chairman of the Women's Board, *ex-officio*. . .

Sec. 2. The elective trustees shall in the first instance consist of those nine trustees in office January 15, 1923, whose terms expire in 1924, 1925 or 1926, together with nine-

teen (19) trustees to be elected at the annual meeting to be held in 1923, of whom four shall be elected to serve until 1924, four to serve until 1925, four to serve until 1926 and seven to serve until 1927. At each succeeding annual meeting thereafter seven trustees shall be elected to succeed those whose terms are about to expire, and each trustee so elected shall hold office for four years from the date of his or her election and until his or her successor shall have been elected.

Sec. 3. Vacancies on the board of trustees from whatever cause may be filled by the remaining trustees until the next annual meeting, when such vacancy shall be filled by the election of a trustee for the unexpired term.

Sec. 4. At its first meeting after the annual meeting of the members, or so soon thereafter as may be, the board of trustees shall elect officers, shall choose the elective members of the Women's Board and shall make appointments to the Medical Staff of the Hospital pursuant to these by-laws.

ARTICLE III

Executive Committee

Section 1. The president, the vice-presidents, the secretary and the treasurer, together with the chairman of each standing committee, the chairman of the women's board and the superintendent of the hospital shall constitute the executive committee.

Sec. 2. The powers of the board of trustees are hereby delegated to the executive committee but said committee shall exercise those powers only if, as and when the best interests of the hospital shall require such action in the interim between regular meetings of the board of trustees.

Sec. 3. It shall be the duty of the executive committee to keep a check on the progress of the work done by all the standing committees and to harmonize and co-ordinate the

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same; to facilitate and simplify the work of the trustees by causing all questions of hospital policy brought to its attention to be promptly considered and prepared for submission to the trustees, with recommendations thereon, by the proper committee or official.

Sec. 4. All action taken by the executive committee shall be fully reported to the trustees at their next meeting.

ARTICLE IV

Membership

Section 1. Any person elected by the trustees to membership who shall pay the membership fee herein provided for, shall become a member of the corporation from and after the first day of July then next following, provided, however, that the trustees may, in their sole discretion, admit any person to membership at any time during the year.

Sec. 2. The membership fee shall be five dollars (\$5.00) per annum payable in advance or before the first day of July in each year, provided, however, that the trustees may, in their sole discretion, remit all or part of the said membership fee in the case of members who are also members in good standing in any auxiliary board, guild or other organization affiliated with Butterworth Hospital.

Sec. 3. Failure to pay such membership fee when due and payable shall operate to suspend the membership of the person in default; and failure to pay the same by the first day of September, after due notice of arrears given in such manner as the trustees may prescribe, shall automatically terminate such membership.

ARTICLE V

Standing Committees

Section 1. The standing committees of the board of trustees shall consist of the House Administration Commit-

tee, Finance Committee, Committee on Accounts, Nursing Committee, Medical Committee, Property Committee, Social Service Committee, Committee on Publicity and such other committees as the board of trustees shall create.

Sec. 2. Each standing committee shall consist of such number of persons, not less than three, as the trustees may prescribe.

Sec. 3. The membership of the House Administration Committee, the Nursing Committee, and the Social Service Committee shall include in each case, two persons nominated thereto by the Women's Board.

Sec. 4. The president shall appoint all standing committees and the chairman thereof as soon as may be after the annual meeting in each year.

Sec. 5. The superintendent shall be *ex-officio* an advisory member and secretary of each standing committee.

Sec. 6. It shall be the duty of each standing committee to acquaint itself with the branches of hospital administration and the problems thereof falling within the scope of such committee's work; to report thereon regularly to the trustees with recommendations; and to consider and act promptly upon all other matters committed to it. No standing committee shall have power to act for the trustees unless expressly authorized so to do by the trustees or by the executive committee.

Sec. 7. It shall be the duty of the *House Administration Committee* to study the administrative problems arising in the operation of the hospital with a view to recommending corrective policies; to assist in developing an efficient and economical administration of the business affairs of the hospital; and to receive and investigate complaints of mismanagement and to recommend corrective measures in regard to the same.

Sec. 8. It shall be the duty of the *Finance Committee* to consider and recommend plans for securing funds for the

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hospital; to supervise the execution of the same when adopted by the trustees; and, with the treasurer, to have general supervision over the endowment funds of the hospital and to make recommendations as to the investment thereof.

Sec. 9. It shall be the duty of the *Committee on Accounts* to supervise the general accounting system of the hospital; to supervise and audit the accounts payable, to supervise, in harmony with the approved policies of the social service committee, the collection or other disposition of the accounts receivable; to render to the trustees a monthly statement of the operating financial condition of the hospital; and to act as a membership committee.

Sec. 10. It shall be the duty of the *Medical Committee* to cooperate with the superintendent and the proper committee from the staff of the hospital in formulating, and to recommend to the trustees from time to time, policies designed to develop and improve the medical and surgical service of the hospital; to receive from the superintendent his recommendations as to suggested staff appointments; to consider the same and to make to the trustees such recommendations thereon as it shall deem proper; to consider with the superintendent and to report to the trustees upon all cases of charges against physicians involving their standing as practitioners in the hospital or as members of the staff; to scrutinize the quality of medical and surgical service rendered in the hospital and to make a monthly report thereon to the trustees.

Sec. 11. It shall be the duty of the *Nursing Committee* to supervise the training and education of the nurses of the hospital and to plan for the extension and improvement of the same; to co-operate with the superintendent and the superintendent of nurses in matters relating to discipline; to aid in securing for the pupil nurses proper social and recreational activities; to scrutinize the quality of nursing service

rendered hospital patients and recommend such changes as may be necessary.

Sec. 12. It shall be the duty of the *Property Committee* to give special attention to the condition of all physical property of the hospital and to advise with the superintendent regarding repairs and maintenance thereof; to consider and make recommendations concerning alterations and enlargements of the plant of the hospital, including equipment as well as buildings and grounds.

Sec. 13. It shall be the duty of the *Social Service Committee* to consider and define the scope of the social service of the hospital and to recommend to the trustees policies in regard thereto; to supervise, develop and improve the social service activities of the hospital in connection with applicants for treatment in the hospital or the out-patient department, resident patients and the follow-up care of discharged patients; to supervise the administration of the free bed service in the hospital and of all funds available for free or part free service therein; to advise with the committee on accounts concerning the handling of past-due accounts of patients; to co-operate with other existing social agencies and to correlate therewith the social service of the hospital.

Sec. 14. It shall be the duty of the *Committee on Publicity* to study the needs of the hospital in the field of educational publicity; to advise and consult with the chairman of all other committees and with the superintendent concerning methods of meeting those needs; to formulate and recommend to the board of trustees from time to time educational publicity policies for the hospital; and, upon approval of such policies, to supervise the execution thereof in co-operation with the chairmen of all interested committees and the superintendent. Said committee shall also supervise the preparation and publication of all reports published by the hospital.

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ARTICLE VI

Superintendent

Section 1. Subject to the direction and control of the trustees, the management of the hospital shall be vested in a superintendent appointed by the trustees.

Sec. 2. When acting within the scope of his authority, the superintendent shall, in all matters pertaining to hospital administration, directly represent the trustees, and he shall be responsible to them alone for the proper performance of his duties.

Sec. 3. It shall be the duty of the superintendent to promulgate and enforce all rules and regulations for the proper conduct of the hospital made by or under the authority of the trustees; and until such have been made the superintendent shall have authority himself to make and enforce all necessary rules and regulations for the proper conduct of hospital routine.

Sec. 4. In all cases of disputed authority or uncertainty as to the meaning of these by-laws or the rules and regulations of the hospital, the decision of the superintendent shall be operative until a ruling shall have been rendered by the trustees or by the executive committee.

ARTICLE VII

Medical Staff

Section 1. General Government: The medical staff of Butterworth Hospital, and all medical and scientific work carried on therein, shall be governed by these by-laws and by such rules and regulations consistent herewith as may be enacted from time to time by or under the authority and with the approval of the Board of Trustees.

Sec. 2. Staff Groups: The General Staff shall consist of all those physicians and surgeons who may be appointed by

the Board of Trustees to serve the Hospital in any capacity; and it shall be divided into the following groups:

(1) The Consulting Staff, consisting of men active in practice and qualified to act as consultants, not members of any other group of the General Staff. Members of the Attending Staff hereafter retiring therefrom by operation of the age limit hereinafter provided for shall be presumptively eligible for appointment to the Consulting Staff.

(2) The Senior Attending Staff, consisting of active practitioners who are not members of the attending staff of another hospital. Appointees to this staff group will ordinarily be required to have had five years of experience in active hospital staff service. From and after January 1, 1928, attainment of the age of sixty years, by any member of this group, shall automatically effect his retirement therefrom.

(3) The Junior Attending Staff, consisting of young men who have served their internship but who are not yet qualified by age and experience for appointment to the Senior Attending Staff and who are not members of the attending staff of another hospital. Appointments to the Senior Attending Staff will ordinarily be made from this group.

(4) The Resident Staff, consisting of those physicians and surgeons resident in the Hospital, and on full-time duty therein, as interns or otherwise, provided, however, that the Trustees may appoint any laboratory specialist employed by the Hospital to any other staff group.

(5) The Associate Staff, consisting of active practitioners who are not members of the attending staff of another hospital, but who are qualified by training and experience to give competent care to their private patients in the hospital.

Sec. 3. General Qualifications: Membership upon the General Staff shall be restricted to physicians and surgeons of good character and professional standing who are competent in their respective fields; who adhere to the minimum

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standards of the American College of Surgeons and to the code of ethics of the American Medical Association; and who signify their willingness to abide by the by-laws, rules and regulations of Butterworth Hospital.

Sec. 4. Staff Appointments: Appointments to the General Staff shall normally be made by the Board of Trustees annually in the month of January, or so soon thereafter as may be, shall run until the making of the regular staff appointments of the following year, and shall be subject to reappointment as of course, following faithful and efficient service, provided, however, that appointments to the reorganized staff shall be made as soon as may be after May 15, 1923, and provided, further, that special appointments may be made at any time in the discretion of the Board of Trustees. Every appointment to the Attending Staff shall be made to the Senior Grade or the Junior Grade and to a specific major department thereof.

Sec. 5. Same; Procedure: Applications for staff appointment shall be made in writing addressed to the President and filed with the Superintendent. Recommendations as to all candidates for staff appointment shall be made to the Board of Trustees by the Medical Committee thereof after due consideration of such candidates and after full consultation thereon, after 1923, with the Staff Executive Committee and the Superintendent.

Sec. 6. Removals: The Board of Trustees reserves the right to remove any officer or member of the General Staff, or to deprive any physician or surgeon of the privilege of the Hospital whenever, in its sole judgment, the good of the Hospital or of the patients therein, may demand it.

Sec. 7. Restriction on Practice: Practice in Butterworth Hospital shall be restricted (a) to members of the General Staff and (b) to such other competent physicians and surgeons as may be invited to practice therein by or under authority of the Board of Trustees.

Sec. 8. Practice by Invitation: Invitation to practice in the Hospital may be issued upon such conditions and in such numbers and to such persons as the Board of Trustees, after consultation with the Staff Executive Committee, shall decide, provided, however, that it shall be the policy of the Hospital to encourage proper utilization of its available facilities by competent physicians and surgeons, and provided further, that an active member of the attending staff of any other approved hospital shall be presumptively entitled to practice in the Hospital by invitation. Every invitation to practice in the Hospital shall be subject to revocation by the Board of Trustees for any reason deemed by it sufficient.

Sec. 9. Clinical Divisions: The medical service of the Hospital and the Out-Patient Department, and likewise the Attending Staff, shall be divided by the Board of Trustees from time to time, according to developing needs, into appropriate major divisions and subdivisions. Subject to modifications, the major divisions shall be five in number, namely, Medicine; Surgery; Eye, Ear, Nose and Throat; Obstetrics and Pediatrics.

Sec. 10. Appointive Staff Officers: The principal officers of the General Staff shall consist of a Chief of Staff and a group of other officers, co-ordinate with each other, consisting of one Chief of Service for each major clinical division or service and one Supervisor of the Out-Patient Department. All of said officers shall be appointed by the Board of Trustees from the Senior Attending Staff. They shall hold office for two years and shall be eligible for re-appointment, provided, however, that the term of those officers who are appointed in 1923 shall expire with the making of the staff appointments in January, 1925. Commencing in January, 1925, the members of the Senior Attending Staff may nominate biennially three qualified candidates for each of the offices of Chief of Staff and Supervisor of the Out-

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Patient Department; and the members of the Senior Attending Staff in each major clinical division may nominate three qualified candidates for Chief of Service in such division. The Trustees may, in their discretion, at any time appoint, or provide for the appointment of a Vice Chief of Staff, a Vice Chief of any service, or a Vice Supervisor of the Out-Patient Department.

Sec. 11. Staff Executive Committee: The appointive officers of the staff, together with the Superintendent as an advisory member, shall constitute the Staff Executive Committee, provided, however, that the Trustees may enlarge the same at any time, if in their judgment it is advisable, by the addition of other members of the General Staff in such manner as the Trustees shall direct. Said Executive Committee shall meet regularly at least weekly and specially on request of the Chief of Staff, the Superintendent, or any two other members thereof.

Sec. 12. Same; Powers and Duties: The Staff Executive Committee shall have power, subject to the control of the Board of Trustees, and it shall be the duty of said Committee, to formulate and adopt all necessary rules, regulations and measures, in harmony with the declared policies of the Board of Trustees, for the government of the General Staff, the clinical organization of the Hospital and all the professional and scientific work properly to be carried on therein. More specifically it shall be the duty of the Staff Executive Committee:

- (1) To define the privileges and responsibilities of members of the several staff groups.

- (2) To provide in detail for the proper organization of the General Staff and the several groups thereof.

- (3) To provide in detail for the proper organization of the clinical services of the Hospital and the Out-Patient Department thereof.

- (4) To define the executive powers and responsibilities

of the respective Chiefs of Service and of the Supervisor of the Out-Patient Department.

(5) To provide for scientific meetings of the staff, to be held at least monthly except during mid-summer, regular attendance at which shall be required of the attending and resident groups of the staff.

(6) To prescribe the proper keeping, by all practitioners in the Hospital, of suitable case records as required by the Hospital; to provide for the systematic and thorough technical review of all such records by a committee of the staff, and for the submission thereof, where desirable in the interest of better hospital practice, to group discussion by the staff.

(7) To provide, under supervision of the respective Chiefs of Service and by rotation of service on the part of the Attending Staff, continuous and adequate professional services without charge to all free and part-pay patients in every department of the Hospital.

(8) To make provision for adequate and systematic medical instruction to pupil nurses, as may be requested by the training school Administration.

(9) To provide adequate and systematic opportunity to all interns in the Hospital to profit educationally by their internship.

(10) To formulate policies calculated to maintain a standard of professional service and scientific work in the Hospital which shall be as high and as progressive as is reasonably possible and in no event below the minimum standard defined by the American College of Surgeons.

(11) To prescribe the full utilization of all of the available facilities of the Hospital for the study, diagnosis and treatment of patients.

(12) To provide for a progressive standardization of hospital procedure wherever possible.

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(13) To promote group practice and the advancement of scientific medicine and research in the Hospital.

(14) To formulate a sound policy with respect to consultation and such reasonable degree of supervision over all practice in the Hospital as the best interests of the Hospital and the patients therein may demand.

(15) To co-operate with the Superintendent in securing proper execution of the approved medical policies of the Hospital and the observance of all rules and regulations related thereto.

Sec. 13. Chief of Staff: The Chief of Staff shall be the presiding officer of the General Staff, the Attending Staff and the Staff Executive Committee. He shall keep in touch with the medical administration, professional and scientific work and needs of the Hospital and each department or service thereof, and shall recommend to the Staff Executive Committee, for their consideration and appropriate action, measures calculated to improve such administration and professional work, and to meet such needs. He shall supervise the performance, by the Staff Executive Committee, of their duties to the Hospital, and shall supervise the execution of policies adopted by said Committee acting within the scope of its powers.

Sec. 14. Joint Conference Committee: In order to maintain contact between the Board of Trustees and the medical administration of the Hospital there shall be a Joint Conference Committee consisting of the Medical Committee of the Board of Trustees and the Staff Executive Committee or a sub-committee of three members thereof including the Chief of Staff. Said Joint Conference Committee shall meet regularly each month and specially on the request of the chairman of either group thereof. The chairman of the Medical Committee shall act as chairman of said Committee, and the Superintendent as secretary thereof. It shall be the duty of said Committee, by presentation and

discussion of questions affecting the medical administration of the Hospital and by any other appropriate means, to promote mutual understanding and co-operation between the Board of Trustees and the General Staff, to the end that the most efficient general administration of the affairs of the Hospital, by the Board of Trustees, may be assured.

Sec. 15. Group Views: The General Staff, or any group thereof, or the members of any service, shall at all times have the right through representatives of their choosing, to submit to the Board of Trustees any criticisms, suggestions, or expression of views touching the medical or general administration of the Hospital.

ARTICLE VIII

Women's Board

Section 1. There shall be created a board of women consisting of twenty-four (24) members elected annually by the trustees, together with the chief presiding officer of each guild or society affiliated with the hospital.

Sec. 2. Subject to the final authority of the trustees the women's board shall have general supervision and control over the affiliation, organization, financial policies and methods and the program of activities of all guilds and other societies connected with the hospital, and to this end may adopt all necessary rules and regulations. Said board shall co-operate with the trustees (1) in stimulating, securing and co-ordinating volunteer service to the hospital; (2) in increasing the usefulness and efficiency of the hospital; and (3) in winning increased public understanding and support of the hospital.

Sec. 3. Subject to these by-laws and the approval of the trustees said board shall adopt such by-laws and rules for its own government as it may deem desirable, provided,

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however, that such by-laws shall, among other things, make provision:

(a) For officers consisting of a chairman, one vice-chairman or more, a secretary and treasurer, to be elected annually by said board from its membership.

(b) For regular meetings at least monthly and for an annual meeting.

(c) For an annual report to the trustees covering the financial and other activities of said board and of all guilds and societies affiliated with the hospital.

(d) For submitting annually to the trustees, at the first meeting thereof following the annual meeting of the corporation, nominations for membership upon the women's board.

(e) For nominating each year two representatives to serve upon each of the following committees of the Board of Trustees: House Administration Committee, Nursing Committee and Social Service Committee.

Sec. 4. Said board may call joint meetings of the membership or officers of the affiliated guilds and societies at any time and shall call at least one such meeting annually.

Sec. 5. It shall be the duty of the superintendent to attend all meetings of said board whenever possible, unless excused therefrom by the chairman of said board.

ARTICLE IX

Affiliated Guilds and Societies

Section 1. All guilds and societies now or hereafter connected with the hospital shall be subject to these by-laws and to the rules and regulations of the women's board adopted pursuant hereto.

Sec. 2. A new guild or society can become affiliated only by vote of the women's board.

Sec. 3. Each guild and society shall cause an accurate

record to be kept of all moneys received and expended by it and shall file with the women's board annually, or oftener if requested, a detailed financial statement and report of its activities.

Sec. 4. No guild or society shall seek to raise money from others than its own members without first seeking and obtaining the approval of its methods by the women's board, and no money-raising method shall be adopted or approved which is not in harmony with the financial policy of the trustees.

Sec. 5. The connection of any guild or society with the hospital may be severed by the vote of two-thirds of all of the trustees.

ARTICLE X

Meetings

Section 1. The annual meeting of the corporation shall be held at 8:00 P. M. on the third Tuesday in January at the hospital or at such other hour or place in the city of Grand Rapids, Michigan, as shall be designated by the trustees. No formal notice of this meeting shall be required.

Sec. 2. Special meetings of the corporation may be held at any time pursuant to the call of the trustees upon three days' notice by mail or by publication once in a daily newspaper published in the city of Grand Rapids.

Sec. 3. The trustees shall meet annually for organization as soon as may be after the annual meeting of the corporation and shall meet regularly each month at a time and place to be fixed by rule. They shall meet specially on call of the president, or of the executive committee, or of any five trustees, upon reasonable notice to be given by the secretary of the time and place of such special meeting. Except as otherwise prescribed in these by-laws, a quorum of the trustees present at any special meeting duly called shall

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have power to transact any business whether included in the notice of the meeting or not.

Sec. 4. The executive committee shall meet on call of the chairman, upon reasonable notice, whenever in the judgment of himself, or any three members of said committee, or any standing committee, or the superintendent, it shall be necessary between meetings of the trustees to give immediate attention to matters of importance to the hospital.

Sec. 5. Every standing committee shall meet at the request of its chairman or any other member, or of the superintendent, and shall in any event meet regularly each month at a time to be decided by such committee in consultation with the superintendent.

Sec. 6. So far as possible the annual meetings of the women's board and of each affiliated guild and society shall be held between the close of the fiscal year and the third Tuesday in January.

ARTICLE XI

Quorum

Section 1. At any meeting of the trustees twelve (12) shall constitute a quorum, and at any meeting of the executive committee a majority shall constitute a quorum.

Sec. 2. At any meeting of the corporation those present shall constitute a quorum.

Sec. 3. Whenever a quorum is present at any meeting, any measure properly before the meeting and receiving the affirmative vote of a majority of those present and voting, shall, except where these by-laws expressly require a larger vote, be deemed carried.

ARTICLE XII

Miscellaneous

Section 1. The fiscal year of the hospital and of all affiliated groups shall be the calendar year.

Sec. 2. All annual reports to the trustees, the women's board or the corporation shall cover the fiscal year and shall be completed and submitted at or before the annual meeting of the corporation.

Sec. 3. Any officer of the board of trustees and any officer or member of the women's board may be removed from office in the sole discretion of the trustees by the vote of a majority of all the trustees.

Sec. 4. It shall be the duty of the trustees to provide adequate protection to the hospital against infidelity on the part of all officers and employees who handle funds of the hospital, by such bonds of surety and indemnity, procured at the expense of the hospital, as the trustees shall deem necessary and proper.

Sec. 5. Any written contract of the corporation, duly authorized by the trustees, may be signed by the president and either the secretary or the treasurer, or by such other officer or officers as the trustees may specially authorize and direct.

ARTICLE XIII

Amendments

Section 1. These by-laws may be amended or repealed and new by-laws adopted by the vote of a majority of all of the trustees at any regular or special meeting thereof provided general notice of the proposal to alter the by-laws shall have been mailed to each trustee at least five (5) days before the meeting.

BY-LAWS OF THE GREATER COMMUNITY ASSOCIATION, CRESTON, IOWA ¹

The following By-Laws were duly adopted by the Board of Regents of the Greater Community Hospital Association

¹ Another and considerably shorter set of by-laws.

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at a special meeting held at the office of the Association on the 1st day of January, 1919.

ARTICLE I

The President and Vice President shall perform their duties as set forth in the Articles of Incorporation, and all other duties incident and pertaining to their respective offices in like or similar associations.

ARTICLE II

It shall be the duty of the Secretary to keep accurate minutes of the meetings of the members, the Board of Regents, and the Executive Committee and to record the same in a suitable, permanent Record Book, as approved by the respective bodies; to keep an accurate account of, and pay over to the Treasurer, all moneys coming into his hands; to draw all orders upon the Treasurer as authorized by the Board of Regents or Executive Committee, and keep an accurate account of the same; to keep a complete and accurate record and account of the business and financial affairs of the Association, in such a manner that the condition, business, and affairs of the Association may be readily ascertained at any time by the Board of Regents or the Executive Committee. The Secretary shall perform all other duties pertaining to the office of Secretary in like or similar Associations.

ARTICLE III

It shall be the duty of the Treasurer to receive and receipt for all funds of the Association coming into his hands as such, and to disburse the same only on written orders duly drawn by the Secretary; to make to the Association at its annual meeting a full written report of all his transactions showing fully the receipt and disbursements of the funds of the Association and the balance of such funds in his hands; to execute annually a bond in such amount as may be fixed

by the Board of Regents, to the Association, conditioned upon the faithful performance of his duties, and the accounting for all funds coming into his hands as such Treasurer.

ARTICLE IV

The Board of Regents shall annually select an Executive Committee of five members, which Committee shall be composed of the President and Vice President and three other members of the Association to be selected by the Board of Regents. Said Executive Committee shall perform the duties of, and exercise the powers of, the Board of Regents in such matters as the Board of Regents has not acted upon, and such *interim* matters as may be necessary to act upon when the Board of Regents is not in session. Said Executive Committees shall hold its regular meetings on the first Mondays of October, January, April and July of each year, and it may hold such special meetings upon the call of the President, as may be found necessary from time to time to properly transact the business of the Association. The Executive Committee shall appoint and employ a Superintendent of the Hospital and Nurses' Training School, and a Manager of the business of the Association and such other employes as may be found necessary, and by proper Rules and Regulations prescribe the duties of the same. The Executive Committee shall create such Committees and adopt such Rules and Regulations relating to the Hospital Service, the Nurses' Training School, the Extension Service, and the Social Service of the Association as may be deemed proper and necessary to accomplish the objects and aims of the Association, and to widen and extend its influence and usefulness throughout the territory included in the Greater Community Hospital Association. Three members of the Executive Committee shall constitute a Quorum for the Transaction of business.

APPENDIX 7

STATEMENT OF THE AMERICAN INSTITUTE OF ARCHITECTS REGARDING FUNCTIONS OF THE ARCHITECT¹

The Building

As all buildings are seen, society has a right to demand that none be ugly; the life of the community requires that none be unsafe or dangerous to health; social economy requires that they be not wasteful of space or ill-suited to the purpose for which they are created. Every building is to some extent a public matter—even a private house. No building should be erected that is not an attractive addition to the landscape. A well-designed building is a more valuable property—a better investment. A well-constructed building is a more economical investment. No owner, however gifted in other ways, no contractor, however skilled, can design and build the simplest house equal in beauty, utility and cost to one completed under the guidance of a trained architect.

The Architect

An architect should have a fundamental knowledge of his art as an expression of beauty, of structural requirements and of practical design and planning. The practise of architecture requires business executive ability of a high order. Inasmuch as the owner's financial interests are

¹ This circular is issued for the purpose of supplying information to those outside the profession of architecture who are interested in building.

deeply involved in the architect's action, the integrity of the latter must be above question. The development of a well equipped architect demands long and careful study and preparation.

Registration laws in many states requires a high school training, graduation from a recognized collegiate school of architecture or ability to pass successfully special state examinations and specified terms of practical experience in an architect's office. Such legislation is yearly becoming more widespread and the provisions are increasing in stringency. A very usual preparation for the practise of architecture includes four to six years in a technical school or college, a year or two of travel and an extended apprenticeship in an established office.

The architect must be familiar with the history of architecture, with the various "styles," and with such allied arts as sculpture, craftsmanship, interior decoration and landscape design.

Properly to define and supervise the construction of any but the most elementary structure, the architect must either personally or through his organization have knowledge of all kinds of standard building materials and types of construction, with the ways in which different kinds of work are performed, and a competent understanding of the principles of heating and ventilating, plumbing and sanitation, electrical systems and other special departments of the building industry.

Certain buildings require special ability in exterior design, they must primarily be beautiful. Others require special knowledge of particular methods of construction. Still others require technical familiarity with the peculiar uses for which they are erected.

Therefore the owner should consider the natural tendencies, training and special experience of the architect he proposes to employ for a specific type of building.

The Duties of the Architect and of the Owner

After he has been appointed, an architect obtains his client's description of the requirements, studies the problem from all available angles, advises the client of ways in which the first idea may be improved and makes rough drawings or sketches of the building, expressing this. These sketches should be modified and redrawn until both the owner and architect are satisfied that a completely adequate solution has been found. If an owner is not familiar with drawings as an expression of form, the architect should carefully explain them and if necessary have a model of the final structure made. It should be noted that the manufacture of such a model implies an added expense which the architect cannot fairly be expected to assume. At this period, the owner should give to the study of the problem ample time and should make a personal effort to fully inform the architect and to understand his solution.

When the sketches have been finally approved, working drawings and dimensions and notes and specifications are made. Large scale and typical full size details are often drawn at this time. The production of working drawings is very costly. Changes in them usually involve serious expense. Hence working drawings should not be begun until the scheme is well developed and determined. The owner should freely give his personal time to an examination of these drawings, the details and specifications. Although he may not understand all of the technicalities he will know how the different parts of the work are to be treated and will be able to discuss with the architect points that might otherwise be contrary to his desires.

The next step is that of obtaining proposals from contractors. If competitive bids are desired, the architect usually prepares a list and should carefully examine the ability, financial responsibility and reputation of those he recom-

mends. When the owner selects the contractor, the architect usually feels relieved of responsibility. However, he should report his objections to the owner if he believes the contractor is unsuitable. The owner may employ one general contractor or several for different parts of the work and when a contractor has been selected the architect prepares the contracts and should have the necessary legal knowledge and experience to do this satisfactorily in the ordinary case without the use of an attorney. The American Institute of Architects issues special forms for this purpose as well as for other contractual relations.

During the progress of the construction, the architect supervises the work and he should diligently guard the interests of the owner inasmuch as they might be damaged by inferior work, improper bills or unjustified claims for extra payments. At the same time he should see that the terms of the contract are fulfilled in a just and equitable manner as regards both owner and contractor. In view of the fact that he must remain an unbiased judge of all questions, he should have no financial interest in the building operation and therefore cannot assume any guarantee of the cost to the owner.

The Reasons for Employing an Architect

All building undertakings are better and more valuable if they are made beautiful. A building is a better investment when it is well planned and if it be attractive in appearance. Bad planning, waste space, poor means of circulation, fire hazards, usually result in loss of income, higher percentages of taxes to income and increased insurance rates. In many engineering problems, bridges and towers, for instance, an architect is called into consultation to determine the design just as in more predominantly architectural problems a structural engineer is called in to design the steel skeleton.

The average client is unequipped to design or direct the

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construction of his building. His attempt to do so is as certain to court disaster as would be his untrained effort to supplant his physician for his own cure.

The architect usually saves his client considerable unnecessary expenditures of money by eliminating or lessening the number of expensive changes after the contract has been let. When contractors' competitive bids are received well defined plans and specifications permit accurate estimates thereby eliminating the addition of large sums to guard against uncertainty. The architect obtains for the owner all the benefits that accrue from legitimate competition. If the contract be let on a cost and percentage or fixed profit basis he carefully checks the accounts. He also secures for the owner proper compliance with the contract and the elimination of defective material and workmanship.

The Architect's Charges and the Cost of the Work

The fees to be paid should always be discussed frankly by owner and architect and determined clearly at the beginning of the operation. If the proper amount or rate of charge cannot be settled until the extent of the work has become definite, a preliminary charge for consultation, early sketches or estimates will usually be found acceptable to the architect.

The Schedule of Proper Minimum Charges of the American Institute of Architects defines the customary fees if the work be performed on a percentage basis. If the operation be divided into several contracts the architect's labor is greatly increased, and he eventually performs the work for which a general contractor would be employed, who would probably receive ten per cent for his services. In such event the architect should be adequately paid for such additional services by a marked increase in the percentage of his fee. It is usual for the owner to pay for the cost of special en-

gineering services, traveling expenses, blue-prints, long distant telephone calls and telegrams.

Two other forms of compensating the architect obtain to some extent. The architect may agree with the owner upon a specified lump sum for his services in supplying drawings, specifications and even supervision for the whole operation; or he may be paid for his expenses in doing the work plus an agreed profit which may be either a percentage of this cost or a lump sum for the architect's personal services.

An architect may be employed to make drawings without supervision of the construction or to supervise without having made the design, for this is generally unsatisfactory for both owner and architect.

In general the production of simple standardized work requiring little detail is less expensive than work requiring a large number of detail drawings. The cost of producing drawings for a small operation is proportionately very much higher than for a large one. The office expenses of the architect in producing drawings and specifications is much greater than the average client realizes. Much time is absorbed in the thorough study of the simplest problems. He must usually make many sketches in order to arrive at the best solution. He must be prepared to employ competent and expensive assistance in making the working drawings.¹ To this must be added the cost of specification writing, stenography, rent, drawing materials and other overhead expenses without taking account of the superintendence which usually occupies from six months to a year. Furthermore the architect's office force must be maintained at all times in a high degree of efficiency. Consideration of these facts will show that the usual professional charges of an

¹In 1923 the salaries of competent architectural draughtsmen vary from \$40.00 to \$80.00 per week and many drawings require the exclusive time of one man for several weeks.

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architect are small in comparison with his expenses and the work he does.

The Selection of an Architect

The ability of the architect properly to perform his duties makes for the success or failure of the building entrusted to him. Moreover, he is the disbursing officer of his client, in control of large expenditures. The architect who wisely administers the duties entrusted to him may greatly reduce the cost of a building. If the public realized this fully, they would select with care the architect best fitted to the requirements of each building operation. Except for certain forms of public and semi-public work, a "competition" is not considered by the American Institute of Architects the best means of making such a selection. The custom of asking for preliminary sketches before making a selection and therefore before serious study of the problem can take place, is deplored and condemned. An architect should be selected with the same careful consideration of his work and reputation as an attorney or physician. When this is done, those who build reap the benefit by actually receiving full value for the funds they expend and the public at large is benefited in more beautiful and more useful buildings.

APPENDIX 8

THE STANDARD FORM OF AGREEMENT BETWEEN OWNER AND ARCHITECT ¹

THIS AGREEMENT made the
day of in the year nineteen Hundred and
..... by and between
.....
hereinafter called the Owner, and
.....
..... hereinafter called the Architect,
WITNESSETH, that whereas the Owner intends to erect
.....
.....

NOW, THEREFORE, the Owner and the Architect, for
the considerations hereinafter named, agree as follows:

The Architect agrees to perform, for the above-named
work, professional services as stated in Article 1 of the
"Conditions of Agreement between Owner and Architect,"
hereinafter set forth.

The Owner agrees to pay the Architect at the rate of
..... per cent, hereinafter called the basic
rate, computed and payable as stated in the said "Condi-

(¹ Issued by the American Institute of Architects for use when a
percentage of the cost of the work forms the basis of payment.

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Architects, Washington, D. C.)

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tions," and to make any other payments and reimbursements arising out of the said "Conditions."

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The parties hereto further agree to the following:

CONDITIONS OF AGREEMENT BETWEEN OWNER AND ARCHITECT

ARTICLE 1. *The Architect's Services.*—The Architect's professional services consist of the necessary conferences, the preparation of preliminary studies, working drawings, specifications, large scale and full size detail drawings; the drafting of forms of proposals and contracts; the issuance of certificates of payment; the keeping of accounts, the general administration of the business and supervision of the work.

2. *The Architect's Fee.*—The fee payable by the Owner to the Architect for the performance of the above services is the percentage hereinbefore defined as the basic rate, computed upon the cost of the work in respect of which such services have been performed, subject, however, to any modifications growing out of these Conditions of Agreement.

3. *Reimbursements.*—The Owner is to reimburse the Architect the costs of transportation and living incurred by him and his assistants while travelling in discharge of duties connected with the work, and the cost of the services of heating, ventilating, mechanical, and electrical engineers.

4. *Separate Contracts.*—The basic rate as hereinbefore defined is to be used when all of the work is let under one

contract. Should the Owner determine to have certain portions of the work executed under separate contracts, as the Architect's burden of service, expense, and responsibility is thereby increased, the rate in connection with such portions of the work shall be four per cent greater than the basic rate. Should the Owner determine to have substantially the entire work executed under separate contracts, then such higher rate shall apply to the entire work. In any event, however, the basic rate shall, without increase, apply to contracts for any portions of the work on which the Owner reimburses the Engineer's fees to the Architect, and to the cost of articles not designed by the Architect but purchased under his direction.

5. *Extra Services and Special Cases.*—If after a definite scheme has been approved, the Owner makes a decision which, for its proper execution, involves extra services and expense for changes in or additions to the drawings, specifications or other documents; or, if a contract be let by cost of labor and material plus a percentage or fixed sum; or if the Architect is put to labor or expense by delays caused by the Owner or a contractor, or by the delinquency or insolvency of either, or as a result of damage by fire he shall be equitably paid for such extra service and expense.

Should the execution of any work designed or specified by the Architect, or any part of such work be abandoned or suspended, the Architect is to be paid in accordance with or in proportion to the terms of Article 6 for the service rendered on account of it up to the time of such abandonment or suspension.

6. *Payments.*—Whether the work be executed or whether its execution be suspended or abandoned in part or whole, payments to the Architect on his fee are, subject to the provisions of Article 5, to be made as follows:

Upon completion of the preliminary studies, a sum equal

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to 20% of the basic rate computed upon a reasonable estimated cost.

Upon completion of specifications and general working drawings (exclusive of details) a sum sufficient to increase payments on the fee to 60% of the rate or rates of commission arising from this agreement, computed upon a reasonable cost estimated on such completed specifications and drawings, or if bids have been received, then computed upon the lowest bona fide bid or bids.

From time to time during the execution of work and in proportion to the amount of service rendered by the Architect, payments shall be made until the aggregate of all payments made on account of the fee under this Article, but not including any covered by the provisions of Article 5, shall be a sum equal to the rate or rates of commission arising from this agreement, computed upon the final cost of the work.

Payments to the Architect, other than those on his fee, fall due from time to time as his work is done or as costs are incurred.

No deduction shall be made from the Architect's fee on account of penalty, liquidated damages, or other sums withheld from payments to contractors.

7. *The Owner's Decisions.*—The Owner shall give thorough consideration to all sketches, drawings, specifications, proposals, contracts, and other documents laid before him by the Architect and, whenever prompt action is necessary, he shall inform the Architect of his decisions in such reasonable time as not to delay the work of the Architect nor to prevent him from giving drawings or instructions to contractors in due season.

8. *Survey, Borings, and Tests.*—The Owner shall furnish the Architect with a complete and accurate survey of the building site, giving the grades and lines of streets, pavements, and adjoining properties; the rights, restric-

tions, easements, boundaries, and contours of the building site, and full information as to sewer, water, gas, and electrical service. The Owner is to pay for borings or test pits and for chemical, mechanical, or other tests when required.

9. *Supervision of the Work.*—The Architect will endeavor to guard the Owner against defects and deficiencies in the work of contractors, but he does not guarantee the performance of their contracts. The supervision of an architect is to be distinguished from the continuous personal superintendence to be obtained by the employment of a clerk-of-the-works.

When authorized by the Owner, a clerk-of-the-works acceptable to both Owner and Architect shall be engaged by the Architect at a salary satisfactory to the Owner and paid by the Owner, upon presentation of the Architect's monthly certificates.

10. *Preliminary Estimates.*—When requested to do so, the Architect will make or procure preliminary estimates on the cost of the work and he will endeavor to keep the actual cost of the work as low as may be consistent with the purpose of the building and with proper workmanship and material, but no such estimate can be regarded as other than an approximation.

11. *Definition of the Cost of the Work.*—The words "the cost of the work" as used in Articles 2 and 6 hereof are ordinarily to be interpreted as meaning the total of the contract sums incurred for the execution of the work, not including Architect's and Engineer's fees, or the salary of the Clerk-of-the-Works, but in certain rare cases, e. g., when labor or material is furnished by the Owner below its market cost or when old materials are re-used, the cost of the work is to be interpreted as the cost of all materials and labor necessary to complete the work, as such cost would have been if all materials had been new and if all labor had

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been fully paid at market prices current when the work was ordered, plus contractor's profits and expenses.

12. *Ownership of Documents.*—Drawings and specifications as instruments of service are the property of the Architect whether the work for which they are made be executed or not.

13. *Successors and Assignment.*—The Owner and the Architect, each binds himself, his successors, executors, administrators, and assigns to the other party to this agreement, and to the successors, executors, administrators, and assigns of such other party in respect of all the covenants of this agreement.

The Architect shall have the right to join with him in the performance of this agreement, any architect or architects with whom he may in good faith enter into partnership relations. In case of the death or disability of one or more partners, the rights and duties of the Architect, if a firm, shall devolve upon the remaining partner or partners or upon such firm as may be established by him or them, and he, they or it shall be recognized as the "successor" of the Architect, and so on until the service covered by the agreement has been performed. The Owner shall have the same rights, but in his case no limitation as to the vocation of those admitted to partnership is imposed.

Except as above, neither the Owner nor the Architect shall assign, sublet or transfer his interest in this agreement without the written consent of the other.

14. *Arbitration.*—All questions in dispute under this agreement shall be submitted to arbitration at the choice of either party.

No one shall be nominated or act as an arbitrator who is in any way financially interested in this contract or in the business affairs of either party.

The general procedure shall conform to the laws of the State in which the work is to erected. Unless otherwise pro-

vided by such laws, the parties may agree upon one arbitrator; otherwise there shall be three, one named in writing by each party and the third chosen by these two arbitrators, or if they fail to select a third within ten days, then he shall be chosen by the presiding officer of the Bar Association nearest to the location of the work. Should the party demanding arbitration fail to name an arbitrator within ten days of his demand, his right to arbitration shall lapse. Should the other party fail to choose an arbitrator within said ten days, then such presiding officer shall appoint such arbitrator. Should either party refuse or neglect to supply the arbitrators with any papers or information demanded in writing, the arbitrators are empowered by both parties to proceed *ex parte*.

The arbitrators shall act with promptness. If there be one arbitrator his decision shall be binding; if three, the decision of any two shall be binding. Such decision shall be a condition precedent to any right of legal action, and wherever permitted by law it may be filed in Court to carry it into effect.

The arbitrators shall fix their own compensation, unless otherwise provided by agreement, and shall assess the costs and charges of the arbitration upon either or both parties.

The award of the arbitrators must be in writing and, if in writing, it shall not be open to objection on account of the form of the proceedings or the award, unless otherwise provided by the laws of the State in which the work is to be erected.

The Owner and the Architect hereby agree to the full performance of the covenants contained herein.

IN WITNESS WHEREOF they have executed this agreement, the day and year first above written.
In Presence of

.....	}	as to
.....		as to
.....	}	as to
.....		as to

APPENDIX 9

THE STANDARD FORM OF AGREEMENT BETWEEN CONTRACTOR AND OWNER ¹

THIS AGREEMENT made the
day of in the year Nineteen Hundred and
..... by and between
.....
hereinafter called the Contractor, and
.....
..... hereinafter called the Owner,
WITNESSETH, that the Contractor and the Owner for the
considerations hereinafter named agree as follows:

ARTICLE 1. The Contractor agrees to provide all the materials and to perform all the work shown on the Drawings and described in the Specifications entitled

(Here insert the caption descriptive of the work as used in the Proposal, General Conditions, Specifications, and upon the Drawings.)

.....
.....
.....

(¹Issued by the American Institute of Architects for use when a stipulated sum forms the basis of payment.

The Standard Documents have received the approval of the National Association of Builders' Exchanges, the National Association of Master Plumbers, the National Association of Sheet Metal Contractors of the United States, the National Electrical Contractors' Association of the United States, the National Association of Marble Dealers, the Building Granite Quarries Association, the Building Trades Employers' Association of the City of New York, and the Heating and Piping Contractors' National Association.

Third Edition, Copyright, 1915-1918, by the American Institute of Architects, The Octagon House, Washington, D. C.

This form is to be used only with the standard general conditions of the contract.)

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crease the total payments to per cent of the contract price, and days thereafter, provided the work be fully completed and the Contract fully performed, the balance due under the Contract.

ARTICLE 4. The Contractor and the Owner agree that the General Conditions of the Contract, the Specifications and the Drawings, together with this Agreement, form the Contract, and that they are as fully a part of the Contract, as if hereto attached or herein repeated; and that the following is an exact enumeration of the Specifications and Drawings:

[illegible]

The Contractor and the Owner for themselves, their successors, executors, administrators and assigns, hereby agree to the full performance of the covenants herein contained. IN WITNESS WHEREOF they have executed this agreement, the day and year first above written.

APPENDIX 10

THE STANDARD FORM OF BOND ¹

KNOW ALL MEN: That we
(Here insert the name and address or legal title of the Contractor.)

.....
hereinafter called the Principal, and
(Here insert the name and address or legal title of one or more sureties.)

..... and
..... and

hereinafter called the Surety or Sureties, are held and firmly
bound unto
(Here insert the name and address or legal title of the Owner.)

.....
hereinafter called the Owner, in the sum of
..... (\$.....)

for the payment whereof the Principal and the Surety or
Sureties bind themselves, their heirs, executors, administra-

¹ For use in connection with the third edition of the standard form of agreement and general conditions of the contract.

This form has been approved by the National Association of Builders' Exchanges, the National Association of Master Plumbers, the National Association of Sheet Metal Contractors of the United States, the National Electrical Contractors' Association of the United States, the National Association of Marble Dealers, and the Heating and Piping Contractors' National Association.

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tors, successors and assigns, jointly and severally, firmly, by these presents.

Whereas, the Principal has, by means of a written Agreement, dated entered into a contract with the Owner for

 a copy of which Agreement is by reference made a part hereof;

Now, Therefore, the Condition of this Obligation is such that if the Principal shall faithfully perform the Contract on his part, and satisfy all claims and demands, incurred for the same, and shall fully indemnify and save harmless the Owner from all cost and damage which he may suffer by reason of failure so to do, and shall fully reimburse and repay the Owner all outlay and expense which the Owner may incur in making good any such default, and shall pay all persons who have contracts directly with the Principal for labor or materials, then this obligation shall be null and void; otherwise it shall remain in full force and effect.

Provided, however, that no suit, action or proceeding by reason of any default whatever shall be brought on this Bond after months from the day on which the final payment under the Contract falls due.

And Provided, that any alterations which may be made in the terms of the Contract, or in the work to be done under it, or the giving by the Owner of any extension of time for the performance of the Contract, or any other forbearance on the part of either the Owner or the Principal to the other shall not in any way release the Principal and the Surety or Sureties, or either or any of them, their heirs, executors, administrators, successors or assigns from their liability here-

186 FIRST STEPS IN ORGANIZING A HOSPITAL

under, notice to the Surety or Sureties of any such alteration, extension or forbearance being hereby waived.

Signed and Sealed this day of
19....

In Presence of

.....	}	as to	 (SEAL)
.....			
.....	}	as to	 (SEAL)
.....			
.....	}	as to	 (SEAL)
.....			
.....	}	as to	 (SEAL)
.....			

APPENDIX 11 FORM OF SUBSCRIPTION BLANK ¹

FORM OF SUBSCRIPTION BLANK

Am't..... Duluth, Minn.,.....1921

To assist in building and furnishing the proposed additions to St. Luke's Hospital and in consideration of the subscriptions of others, I hereby pledge and promise to pay to the Finance Committee of St. Luke's Hospital Association, or order

the sum of.....Dollars payable:

10% in Cash herewith			Date Paid	Received by
15% January 1, 1922				
15% July 1, 1922				
15% January 1, 1923				
15% July 1, 1923				
15% January 1, 1924				
15% July 1, 1924				

Or, attached hereto is check for \$.....in full payment.

Obtained by..... Name

Team No..... Address

¹ A suggested form of subscription blank for use in a capital fund campaign, with space for recording information regarding partial payments made. In many instances this partial payment plan will be found a desirable one to follow, inasmuch as, on the one hand, it relieves the giver of the strain of paying his entire subscription at one time and, on the other, provides the hospital with the funds it needs as the construction of the new building progresses.

APPENDIX 12

LISTS OF EMPLOYES OF HOSPITALS HAVING A CAPACITY OF 35, 50, 100 AND 169 BEDS, AND THEIR COMPENSATION

HOSPITAL OF 35 BEDS.*

<i>Position.</i>	<i>No. of Employees.</i>	<i>Salary or Rate.</i>
Superintendent	1	\$175.00 per month
Assistant superintendent	1	90.00
Day supervisor	1	75.00
Night "	1	75.00
General duty, graduates.....	2	75.00
Student nurses	11	6.00 8.00 10.00
Janitor	1	75.00
Cook	1	60.00
Maids	3	25.00

HOSPITAL OF 50 BEDS.*

Superintendent	1	\$175.00 per month
Assistant superintendent	1	110.00
Night superintendent	1	100.00
Bookkeeper and cashier.....	1	50.00
Graduate nurses	3	100.00
Student nurses		12.00 14.00 16.00
Dietitian	1	100.00
Cooks	2	30.00 13.00
Dining room girl.....	1	8.00
Maid	1	10.00
Maids	3	8.00
Laundresses (for nurses only).....	2	.25 per hour
Janitor	1	18.00 per week
Engineer	1	25.00 " "
X-ray technician	1	100.00 per month
Laboratory technician	1	100.00

* For the year 1923.

HOSPITAL OF 100 BEDS.*

<i>Position.</i>	<i>No. of Employees.</i>	<i>Salary or Rate.</i>
Administration.		
Superintendent	1	\$3000.00 yearly
† Doorman	1	85.00 per month
Dietitian	1	100.00
† Bookkeeper	1	125.00
Assistant and secretary	1	75.00
Historian	1	125.00
Switchboard	1	70.00
“	1	60.00
Night clerk	1	75.00
Grounds	3	80.00
† Pathologist (half time).....	1	84.00
Technician	1	125.00
Assistant technician	1	80.00
X-ray and pharmacist.....	1	130.00
House staff, resident.....	1	150.00
“ “ assistants	2	50.00

Nursing Department.

House mother	1	\$ 60.00 per month
Superintendent of nurses.....	1	150.00
Instructor and assistant.....	1	125.00
Operating room supervisor.....	1	100.00
Anesthetist	1	125.00
Night supervisor	1	100.00
Children's supervisor	1	75.00
Private supervisor	1	80.00
Maternity supervisor	1	80.00
Semi-private supervisor	1	75.00
Pupil nurses	38	10.00
Orderlies	3	40.00

Housekeeping Department.

Porter (maternity floor).....	1	\$ 45.00 per month
“ (private floor)	1	45.00
“ (semi-private floor)	1	45.00
“ (children's floor)	1	45.00
Maids	4	40.00
Housekeeper	1	100.00
Linen room supervisor	1	65.00
Laundryman	1	70.00
† Helper	1	75.00
† Ironer	1	68.00
† Laundress	1	60.00
† Girls	6	50.00
Maids	3	45.00

* For the year 1922.

† Indicates living out. Personnel living out take meals in hospital.

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<i>Position.</i>	<i>No. of Employees.</i>	<i>Salary or Rate.</i>
Steward's Department.		
Diet kitchen maids	3	\$ 45.00 per month
† Chef	1	150.00
Assistant and pastry	1	80.00
Helper	1	50.00
Pot washer	1	45.00
Dishwasher	1	45.00
Night cook	1	50.00
Waiter (help)	1	45.00
Waitresses	4	40.00
Engineer's Department.		
† Passenger elevator	1	\$ 85.00 per month
Freight "	1	45.00
General houseman	1	75.00
† Emergency and wall washer	1	75.00
Carpenter	1	100.00
Painter	1	100.00
† Engineer	1	180.00
Assistant engineers	3	{ 125.00
		{ 108.00
		{ 75.00
Foreman, day	1	75.00
Total salaries		\$9085.00
Total personnel		119
Total living in		99
" " out		20

The rather low ratio of personnel to patients is practical only in a compact, conveniently arranged hospital. This hospital has a separate service building, housing, laundry and help. The superintendent's suite and house staff quarters are in the main building. Beds are arranged,

First floor	12
Second "	32
Third "	17
Fourth "	39, including bassinets.

The pathologist is half time. X-ray technician is also the pharmacist, plates being interpreted by the attending roentgenologist.

† Indicates living out. Personnel living out take meals in hospital.

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HOSPITAL OF 101 BEDS.¹

<i>Position.</i>	<i>No. of Employees.</i>	<i>Salary or Rate.</i>
Superintendent	1	\$250.00 per month
Secretary to superintendent.....	1	125.00
Assistant secretary to superintendent..	1	75.00
Historian	1	75.00
Clerk	1	50.00
Resident physician	1	100.00
Intern	1	50.00
Pathologist and director of laboratory (part time)	1	75.00
Laboratory technician	1	75.00
Roentgenologist (part time).....	1	100.00
X-ray technician (board not included..	1	210.00
Superintendent of nurses.....	1	175.00
Instructor	1	125.00
Night supervisor	1	75.00
Surgical supervisor	1	100.00
Anesthetist	1	100.00
Dietitian	1	125.00
Chief engineer (board not included)..	1	120.00
Seamstress	1	40.00
Orderlies	8	11.75 per week
Maids	3	8.00
Cooks	2	15.00
Firemen	2	16.50
Farmer	1	14.00
Laundry employes	5	11.60
Painters	2	30.00

HOSPITAL OF 169 BEDS.²

Administration.

† Superintendent	1	\$550.00 per month
† Bookkeeper	1	125.00
† Cashier	1	150.00
† Night clerk	1	65.00
† Historian	1	100.00
† Historian assistant	1	65.00
† Information clerk	1	70.00
† Messengers	2	35.00
† Telephone operators	2	40.00

¹ For the year 1923.

² For the year 1920-1921.

192 FIRST STEPS IN ORGANIZING A HOSPITAL

<i>Position.</i>	<i>No. of Employees.</i>	<i>Salary or Rate.</i>
Nursing Department.		
† Principal of school.....	1	\$175.00 per month
† Assistant principal of school.....	1	145.00
† Night supervisor	1	115.00
† Operating room supervisor.....	1	135.00
† Chief anesthetist	1	135.00
† Assistant anesthetist and floor super- visor	1	105.00
† Supervisors on floors.....	2	95.00 to \$100.00
† Pupil nurses	39	10.00
† Probationers	7	—
† Social service nurse.....	1	150.00
† Orderlies	4	68.00 to \$105.00
Dietetic Department.		
† Dietitian in charge	1	\$120.00 per month
† Assistant dietitian	1	85.00
† Cooks	3	50.00 to \$110.00
† Maids	7	6 at 35.00 1 at \$40.00
† Cleaners	3	3.00 per day
Steward's Department.		
† Steward	1	\$175.00 per month
† Assistant steward	2	70.00
X-Ray Department.		
† Roentgenologist	1	\$325.00 Salary 100.00 Bonus approx.
† Technician	1	100.00
Pathological Department.		
† Pathologist	1	\$3600.00 yearly
† Technician	1	150.00 per month
Housekeeping Department.		
† Housekeeper	1	\$125.00 per month
† Seamstresses	3	40.00
§ Maids	6	32.00 to \$50.00
† Cleaners, janitor, etc.....	13	3.00 per day
† Elevator man	1	50.00 per month
† Night watchman	1	65.00
† Head laundress	1	70.00
† Washman	1	100.00
† Linen carrier	1	70.00
§ Laundresses	14	32.50 to \$40.00
† Receive board.		
† Receive full maintenance.		
§ Those with lower rates receive full maintenance.		

<i>Position.</i>	<i>No. of Employees.</i>	<i>Salary or Rate.</i>
Engineering Department.		
† Chief engineer	1	\$225.00 per month
Assistant engineers	2	.72 an hour
Helper	1	5.50 per day
Firemen	3	5.50
Repairman	1	5.50
‡ Interns	3	75.00 per month
† Carpenters	1	5.00 per day
† Painters	2	3.50 to \$5.00
† Pharmacist	1	150.00 per month

† Receive board.

‡ Receive full maintenance.

Blank—Receive no maintenance.

APPENDIX 13

ANNUAL EARNINGS AND EXPENDITURES OF HOSPITALS HAVING A CAPACITY OF 35, 50 AND 100 BEDS

HOSPITAL OF 35 BEDS.*

No. of patients admitted during the year.....	444
No. of days of service.....	5472
Daily average	15
No. of out-patients.....	234

Earnings.

Rooms	\$17,532.00
Operating room	1,262.00
Delivery room	295.00
X-ray	1,342.50
Board and cots	368.75
Supplies	276.57
Treatments	177.00
Medicine	28.25
Telephone	47.24
Out-patients	53.90
	\$21,383.21

Expenses.

Pay-roll	\$ 9,520.48
Laundry	2,115.59
Food	5,283.28
Ice	258.40
Heat and gas.....	1,372.97
Postage	18.96
Power	60.00
Express	20.61
Improvement and repairs	441.63
Water	140.96
Training school	172.91
Hospital supplies	1,302.55
House supplies	193.89
Furnishings	608.26
X-ray	166.75
Magazines	34.00
Telephone	239.44
Drugs	393.75
Light	182.09
Office	142.15
Rent	99.00
Publicity	58.41
Table decorations	7.22
Grounds	8.95
	\$22,842.25

* For the year 1923.

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HOSPITAL OF 50 BEDS.*

Number of patients admitted during the year.....	727
Number of days' treatment	9,631
Average number of patients per day.....	26
Number of out-patients.....	85

Earnings.

Room and board	\$28,026.56
Supplies sold	751.01
Four \$500 donations for free beds.....	2,000.00
Sustaining fund	2,677.00
Donations	218.00
Paper fund	52.64
Hospital Day	1,243.17
Board of visiting nurse.....	366.00
From club for hospital mending.....	90.00
Visiting Nurse Association.....	1,000.00
Interest from trustees	2,387.52
Interest	47.47
Garden Fund	67.59
Miscellaneous	9.53
	\$38,936.49

Expenses.

Superintendent	\$ 1,183.40
Nurses	2,867.70
Help	6,649.50
Groceries and provisions.....	14,845.07
Surgical and medical supplies.....	2,494.13
Supplies	1,793.77
Laundry supplies	400.93
Gas	126.38
Electricity	1,355.78
Telephone	188.45
Postage, printing and stationery.....	179.05
Fuel	4,089.88
Water	336.31
Express and freight.....	91.93
Repairs	1,228.57
Grounds	532.73
Furnishings	104.00
Nurses' graduations	150.87
Cooking lessons	72.30
Insurance	275.38
Insurance fund	1,200.00
Appropriation from town.....	50.00
American Hospital Association: Entrance fee, \$8.00; dues, \$10.00	18.00
Miscellaneous	81.16

* For the year 1919-1920.

\$40,315.29

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HOSPITAL OF 100 BEDS.*

Patients' days	26,575
Patients admitted to bed.....	2,537
Average daily number of patients.....	72.8
Average daily cost.....	\$4.74

Earnings.

Room and board.....	\$ 90,398.90
Graduate nurses' board.....	5,801.75
Operating room	9,937.40
Birth fee	918.50
Special hospital nurse.....	5.50
Hydrotherapy	2,939.20
Patients' sundries: drugs.....	3,255.71
" " dressings	1,923.20
Laboratory	10,830.75
X-ray	11,744.80
Baby care	940.45
Guest meals	513.10
Cots	626.00
Telephone	86.68
Miscellaneous	1,655.32
Deep therapy	2,015.00
	\$143,592.26

Expenses.

Administrative	\$ 11,425.55
Maintenance and costs	15,911.01
Household	11,700.86
Laundry	7,021.19
Steward's department	32,950.22
Medical and surgical.....	19,059.94
Operating room	1,636.88
Laboratory	7,409.57
X-ray	8,865.30
Nurses' home	2,719.88
Corporation expenses	717.90
Hydrotherapy	2,248.23
Candy	155.56
Free work for year.....	10,445.57
	\$132,267.66

* For the year 1923.

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HOSPITAL OF 100 BEDS.*

Number of patients.....	4,234
Number of out-patients.....	1,666
Total days hospital care furnished.....	35,098
Average days treatment per patient.....	8.29
Total amount charity work done.....	\$12,815.42
Charity work in excess of donations.....	11,709.72
(This hospital has no endowment fund and expense of all charity in excess of donations must be borne out of earnings from other sources.)	
Average per diem cost per capita.....	5.27

Earnings.

Room rent	\$131,332.05
Operating room	31,684.10
Special nursing	451.00
Radiograph	13,452.50
Medicine	5,533.18
Laboratories	5,006.00
Interest on investment.....	900.00
Interest on note.....	26.95
Rentals	2,310.00
Miscellaneous	357.88
	\$191,053.66

Expenses.

Administration	\$18,107.50
Kitchen	40,706.60
Household	29,451.61
Building (maintenance)	5,049.58
Nurses' training school	16,922.66
Drug department	3,855.61
Laundry	7,835.77
Radiographic department	6,665.67
Laboratory	2,104.51
Operating room	12,704.64
Interest, taxes, etc.....	3,812.29
	\$147,216.44

* For the year 1923.

198 FIRST STEPS IN ORGANIZING A HOSPITAL

HOSPITAL OF 101 BEDS.

Earnings.

	1923	1922
Rooms	\$ 37,176.06	\$ 61,339.17
Wards	24,390.37	
Ambulance service	622.50	700.50
Operating room	5,092.00	1,924.50
Delivery room	1,009.50	200.00
Anesthetics	3,874.00	3,495.00
Laboratory	3,879.00	2,351.10
X-ray	12,644.00	7,945.50
Medicine	2,167.13	220.26
Dressings	3,631.95	304.10
Special nursing	3,699.23	3,716.43
Special nurses' board.....	2,708.22	241.02
Cystoscopy	906.00	44.00
City of D——	5,100.00	5,100.00
County of D——	4,800.00	4,800.00
Interest and dividends.....	26,344.13	40,780.39
Farm rentals	100.00	
Apartment rentals	5,923.79	6,005.54
Apartment rentals	591.67	650.00
Bad debts collected	1,692.31	1,147.18
Discount earned	648.32	113.20
Live stock sales.....	521.69	404.80
	\$147,521.87	\$141,482.69

Expenses.

Bad debts (charged off).....	\$ 1,157.96	
Reserve for doubtful accounts.....	1,800.00	
City charity patients.....	6,519.57	
County charity patients.....	8,497.68	
Salaries—Staff and interns.....	9,810.54	\$ 9,420.99
Salaries—Officers and clerks.....	6,783.46	5,839.00
Salaries—Nurses	7,195.60	5,890.30
Salaries—X-Ray Department	3,621.00	3,756.66
Salaries—Laboratory Department	1,799.35	1,685.76
Salaries—Wages and general housekeeping	10,553.27	10,944.98
House supplies and expense.....	4,950.92	7,529.65
Laboratory supplies and expense.....	426.20	534.59
X-ray supplies and expense.....	1,532.58	1,046.92
Drugs, ether, gas purchased.....	1,486.86	2,514.21
Surgical supplies	4,104.18	3,836.72
Groceries purchased	24,106.47	20,658.84
Meats purchased	5,626.38	5,104.34
Laundry labor	3,009.83	2,957.80
Laundry supplies and expense.....	1,359.78	1,140.69
Carried forward	\$104,341.63	\$82,861.45

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Expenses—Continued.

	1923	1922
Brought forward	\$104,341.63	\$ 82,861.45
Light, heat and power.....	8,573.89	6,677.03
Ambulance expense	322.58	421.04
Plant equipment repairs.....	2,409.90	3,420.79
Building repairs	6,860.42	5,715.36
W— apartment expense.....	241.07	374.93
W— “ “ (extraordinary)	171.25	
Insurance	285.70	1,077.60
Office expense	2,524.86	511.74
Educational and library expense.....	277.54	205.25
Ice	1,181.25	1,192.40
Gas	982.28	1,190.95
Water	2,010.49	1,769.56
Nurses' home expense	198.20	63.11
B— apartment		2,073.69
Repairs and renewals, plumbing and heating	1,357.40	1,721.22
Farm supplies and expense.....	1,603.74	777.59
Live stock feed and expense.....	193.28	196.53
Rebates and allowances to patients.....		1,122.86
Automobile expense	91.44	
	\$133,626.92	\$111,373.10

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